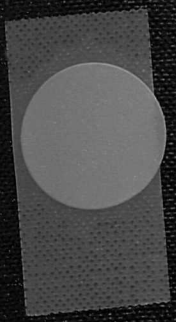

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INDEX.

PAGE

Abortion, Incomplete 45
Abdominal Section, Details in 214
Abdominal Tumours 165
Acupuncture and Paracentesis, Some Notes on ... 49
Addison on Appendicitis 309
Addison's Disease 145
Diagnosis in 148
Advice to the Young 277
Africa, East, A Nurse's letters from 403
Amian, Dr., on the Practice of the Inoculation ... 52
Anæsthetic, an, Asphyxia and Death under ... 419
Anatomy and the Dissecting Room 380
Aneurysm, Thoracic 451
Angina Ludovici, A fatal case of, following Dental Caries 171
Appendicitis, Addison on 309
Diagnosis of 310, 311
Appointments, at Guy's ... 62, 119, 174, 258, 298, 395, 441, 521, 533
System of Making ... 403
Vacant 478
Civil 20, 32, 35, 62, 119, 144, 154, 208, 248, 268, 288, 298, 328, 348, 368, 378, 448, 488, 536
Naval and Military 20, 62, 81, 119, 144, 154, 174, 208, 228, 248, 268, 288, 348, 368, 378, 448, 468, 488, 536
Arms, Grant of, to Guy's Hospital 527
Army Medical Service, Notice of Examination ... 478
Reform of the 152
Pay of the 152
Arthritis, Gonorrhœal 85, 105
Asepsis, *International Clinics* on the Cleaning of Hands 78
Athletic Club, Annual Sports 264
Ground, Proposed Covered Stand at the 325
Sports, Guy's Hospital 264
United Hospitals 286
Atkinson, Mr. R. C., Duels, Ancient and Modern 221

Barber, Mr. H., on Hypochondriasis 517
Beddard, Dr. A. P., appointed Assistant Physician 301
Bermondsey Settlement, The 402
Biennial Dinner, The 305

PAGE

Births 20, 44, 84, 104, 124, 144, 164, 184, 208, 228, 248, 268, 288, 308, 348, 368, 395, 428, 448, 468, 488
Black, Mr. K., A fatal case of Angina Ludovici, following Dental Caries 171
Bolus, Mr. P. R., on Hypnotism 482
Bonsor, Mr. Cosmo, Speech at the Prize Distribution 412
Garden Party to the Nursing Staff 320
Bovril 164
Brailey, Mr. W. H., on Optic Neuritis 355
Bright's Disease, Acute 139, 158
British Medical Association, Grants for Medical Research 218
Brookhouse, Mr. H. O., on Unconscious Mentality 529
Bryant, Dr. J. H., Muscular Atrophy 329
Building Fund, First List of Donations to ... 27

Cæcum, Inflammation of the 311
Cæsarian Sections, Three 460
Calendar 1, 21, 45, 65, 85, 105, 125, 145, 165, 185, 209, 229, 249, 269, 289, 349, 369, 393, 405, 429, 449, 469, 489, 509
Campkin, Mr. P. S., Presidential Address to the Dental Society 463
Cambridge University Pass Lists 15, 194, 255, 306, 437 467, 52
Plan of Examination for Medical and Surgical Degrees 142, 464
Cancer of the Stomach, Perforation as a result of 434
Caries of the Tympanic Ossicles 349
Cephalotripsy, Difficult 401
Chapel Choir, The 422, 438, 481
News 32, 64, 83, 93, 118, 395
Chess Club 535
Chloroform, Death after 477
Chorea, Some interesting Cases of... 209
Christmas, A Merrie 509
at Guy's 7
Christian Science, Historical Description of 100, 110
Cleveland, Dr. A. J., Some Notes on Paracentesis and Acupuncture 49

PAGE

CLINICAL LECTURES—
- Dr. Bryant—
  - Muscular Atrophy 329
- Mr. Fagge—
  - On Caries of the Tympanic Ossicles ... 349
- Dr. Fawcett—
  - Some interesting Cases of Chorea ... 209
- Mr. Higgens—
  - Proptosis 186
- Dr. Horrocks—
  - The Modern Use of the Curette... ... 491
- Mr. Jacobson—
  - Gonorrhœal Arthritis 85, 105
- Mr. Lucas—
  - Glandular Tumours in the Neck ... 469
- Dr. Pitt—
  - On Headaches and their Treatment ... 405
- Dr. Shaw—
  - Perforation of the Stomach as a result of Malignant Growth 429
- Mr. Targett—
  - Incomplete Abortion 45
- Dr. Taylor—
  - Posterior Basal Meningitis 126
  - A Case of Addison's Disease 145
  - Some Abdominal Tumours 165
  - Some Convulsive Disorders 229
- Dr. Washbourn—
  - Influenza 1
  - Typhoid Fever 36
  - Diagnosis of Small-pox 65
- Dr. Hale White—
  - Tubercular Peritonitis 249
  - Acute Peritonitis 269
  - Diabetes 289
  - Venous Thrombosis in Heart Disease ... 371
  - On Thoracic Aneurysm 451
  - Malignant Endocarditis 510

CLUBS—
- Athletic 264
- Chess 535
- Contemporaries 462
- Debating 60, 422, 441, 482
- Glee 438, 529
- Hare and Hounds 447
- Hockey 535
- Lawn Tennis 247, 288, 308, 508
- Rifle 328
- Students' 465
- Swimming 164

CLUBS' UNION—
- Alterations to Rules 1 and 16... 343
- Annual Report and Balance Sheet, 1901-1902 325
- Proposed Covered Stand at Honor Oak Park 325
- Constituent Institutions 396

Collier, Mr. H., Presentation to 14

Collins, Mr. W. E., The Lepers' Home in Jamaica 70

PAGE

Concert, Nurses' Choral Society and Students' Glee Club 438, 529
- Smoking 92, 523
- in the Wards 7, 281

Conjoint Examining Board in England—
- Pass Lists 61, 83, 104, 194, 504
- Increased Fees for D.P.H. Examination 93
- Revised Synopsis of the Examination in Physics 427
- Scheme of Examination for 1903 ... 466

Conjoint Examining Board in Ireland, Pass List 338
- Men, Degrees for 254

Contemporaries' Club 462

Contributions 506

Convulsive Disorders, Some 229

Cordite Manufacture, The Red Line in 356

Coroner's Court, The Hospital and the 501

Cotton, Sister Clemence, Death of. 282

CRICKET—
- Analysis of Batting and Bowling for Season, 1902 327
- Cup Tie 266
- Matches—
  - v. Addiscombe 307
  - v. Beckenham... 227
  - v. Blue Mantles 227, 246
  - v. Camberwell House Asylum ... 247, 287
  - v. Christchurch 247, 348
  - v. City of London School 267
  - v. Eltham 327
  - v. Enfield Lock 246, 307
  - v. Gravesend 307
  - v. Hampstead 267
  - v. Hornsey 287
  - v. Hos.-Scho. 246
  - v. London County C. C. 266
  - v. M. C. C. 286
  - v. Middlesex Hospital 266
  - v. New Eltham 288
  - v. Reigate 266
  - v. R. I. E. C. 266
  - v. Sevenoaks School 308
  - v. Surbiton 246
  - v. Thespids 228
  - v. Wanderers 265
  - v. Wellingborough Masters 327
  - Past v. Present 287

Curette, The Modern use of the 491, 529

Curious Case, A 345

Dance, The Residents' 523

Davidson, Mr. G. G., B.A., Acute Bright's Disease 139, 158

Dean of a Provincial Medical School, To the ... 114

Deaths 20, 44, 64, 84, 104, 144, 164, 184, 208, 248, 268, ... 288, 328, 348, 368, 448, 488

PAGE

Debating Society—Debates:
"That the time is ripe for the abolition of the Monarchy, and for a Republic to be established in its stead" 60
"That the Surgeon is of more practical utility to the community than the Physician" ... 441
"That this House views with alarm the increasing American influence in this country" 482
The Secretary's Appeal... 422
Deck, Mr. E. F., On the Removal of the Dental Pulp 178
Dental Appointments 521
Caries, A fatal case of Angina Ludovici following 171
Museum, Recent additions to the ... 118
Pass Lists 224
Prizes 254
Pulp, On the removal of the 178
School, The 391
Students, To, on beginning work at the Hospital 383
Students, University Degrees for ... 489
Syllabus, Revised for L.D.S. Eng., Examination 323
Travelling Scholarship 198
Dental Society—
Annual Dinner 81
General Meeting 261
Officers for 1902–3 261
Presidential Address. By Mr. P. S. Campkin 463
Papers read before the Dental Society—
A Consideration of the relationship between Superior Protrusion and Mouth Breathing. By Mr. H. C. Visick 16
The Removal of the Dental Pulp. By Mr. E. Field Deck 178
On Erosion. By Mr. J. A. Donald ... 314
Hypoplastic Teeth. By Mr. A. L. Mason 530
Diabetes 289
Diagnosis, Cases for 215, 237, 254, 323
Commentaries on 228, 248, 268, 328
Dinner, Annual House 423, 438
A Send-off, to Mr. W. C. C. Pakes ... 31
Biennial, The Guy's Hospital ... 261, 305
Dental Society's Annual 81
Officers and Servants' 94
South African Civil Surgeons' 245
Diphtheria, Case of Diaphragmatic and Vagus Paralysis after: Death 194
Its Cause and Cure! 420
Diploma in Public Health, Conjoint Board increased fees for the 93
Dobson, Mr. T. H. B., M.B., Two Cases of Laparotomy under Eucaine 354
Doctors, Two Ship's 240

PAGE

Doctor, the title of, Resolution upon, by a Committee of the Royal Colleges of Physicians and Surgeons 218
Donald, Mr. J. A., On Erosion of the Teeth ... 314
Douche, Danger of the 172
Duels, Ancient and Modern 221
Dunn, Mr. L. A., resigns the Wardenship of the College 137
Durham University Pass Lists ... 194, 224, 427, 437

Endocarditis, Malignant 510
Erosion of the Teeth, On 314
Eucaine, Two Cases of Laparotomy under ... 354
Examination Results—
B.S. London 526
Conjoint Board in England—
Final Examination 104, 194, 504
Second 61, 195, 504
First 61, 195, 504
Dental Students' Prizes—
Second Year's Students 254
First 254
D.P.H. Cambridge 467
D.P.H. Conjoint Board, Eng. 83
D.P.H. Conjoint Board, Irel. 338
D.P.H. Durham 224
F.R.C.S. Edin. 194
F.R.C.S. Eng. 224, 306, 504
Golding-Bird Medal and Scholarship ... 222
Intermediate M.B. Lond. 83
Junior Proficiency Prize 222
L.D.S. Eng.—Final Examination 224
First Professional Examination 224
M.B. Cambridge 15, 437
M.B. Durham 194, 224, 427, 437
M.B. London 238, 476, 526
M.D. Cambridge 194, 255, 306, 526
M.D. Durham 224
M.D. London 15, 526
M.D. Oxford 15
Michael Harris Prize 222
M.R.C.P. London 194, 338, 476
M.S. London 526
Practical Dentistry Prize 254
Preliminary Scientific Examination, London 83
Wooldridge Memorial Prize 222
Eyre, Dr. J. W. H., elected Bacteriologist to Guy's Hospital 321

Fagge, Mr. C. H., appointed Aural Surgeon to Guy's Hospital 219
On Caries of the Tympanic Ossicles 349
Fawcett, Dr. J., elected F.R.C.P. London ... 194
On Some Interesting Cases of Chorea 209

PAGE

Final, My 420
Fives Court, The 183
FOOTBALL—ASSOCIATION MATCHES—
v. Beckenham... ... ... 63, 507
v. Eastbourne 63
v. Ewell 103
v. Guildford 447
v. Kenley 488
v. London Hospital 124, 144
v. Old Eastbournians 64
v. Reigate 104
v. St. Bartholomew's Hospital ... 104, 124
v. St. Mary's Hospital 143
v. St. Thomas's Hospital 124
v. South Norwood 508
v. Surbiton Hill 468
v. Woodford Albion 447
Appeal by the Captain 403
Cup Ties 104, 124, 143, 468
Fixtures for Season 1902–3 397
List of Matches by Third Team 535
Report of Season 1901–2 ... ... 184, 195
RUGBY MATCHES—
v. Beckenham 63, 488
v. Bedford 487
v. Cambridge University 446
v. Catford Bridge 446
v. Croydon 102, 467
v. Dulwich College 507
v. Harlequins 122
v. Kensington... ... ... 102, 428, 467
v. King's College Engineers 447
v. King's College Hospital 123
v. Lennox 446
v. London Hospital 103, 121, 507
v. London Scottish 534
v. London and Westminster Bank... ... 507
v. Merchant Taylors... ... ... 123, 447
v. Old Charltonians 507
v. Old Leysians 62
v. Old Merchant Taylors 534
v. Rosslyn Park 62
v. St. Bartholomew's Hospital 83
v. St. Mary's Hospital 143
v. St. Thomas's Hospital 506
v. Wasps 507
Appeal by the Captain 403
Cup Ties 83, 103, 121, 123, 143
Forsyth, Mr. D., M.B., A Case of Gastric Ulcer, with Tetany and Di-aceturia 40
Frant (Sussex), In praise of 343
Freshmen, Welcome to 369
F.R.C.S., Eng., Surgery Classes, Preparatory ... 93, 112
Notice of Examination 462

Gastric Ulcer, A Case of, with Tetany and Di-aceturia 40

PAGE

General Practice, Jottings in 391
Golding-Bird Gold Medal and Scholarship ... 222
Gonorrhœal Arthritis 85, 105
Causation of 88
Diagnosis of 105
Guildhall Library 490
Guy's Hospital Athletic Club 264
Biennial Dinner 261
Building Fund 27
Chapel Services 481
Chess Club 535
Christmas at 7
Clubs' Union 343, 396
Debating Society 60, 422, 438, 441, 482
Dental Travelling Scholarship ... 198
Gazette, should contain more clinical matter 458
Grant of Arms to 527
Hockey Club 535
Reports, Vol. 57 35
Lawn Tennis Club 247, 267, 288, 308, 508
Lord Mayor's Appeal on behalf of 21
Officers' and Servants' Dinner ... 94
Physiological Society ... 402, 438
Rifle Association 328
Students' Club 465
Swimming Club 164
Theatricals at 11
Guyoscope, Reminiscent of the 79

Habershon, Dr., on Appendicitis... 311
Hare and Hounds, United Hospitals ... 468, 488, 535
Haywood, Mr. Henry, Death of 91
Headaches and their Treatment 405
Heart Disease, Venous Thrombosis in 371
Heatherley, Mr. F., F.R.C.S., Medicine and the Motor Car 284
Henriette Raphael Nurses' Home, Opening of the 302
Hereafter, The 257, 304, 325, 345, 402
Higgens, Mr. C., On Proptosis 186
Hockey Club, General Meeting 535
Homœopathy, Historical Description of 97
Horrocks, Dr. P., The Modern use of the Curette 491
Hospital Practice, Days and Hours of Attendance on 390
Hovis Food 395
Howse, Sir H. G., Resignation of 125, 280
Humour 174, 460, 481, 506
Hypnotism 482
Hypoplastic Teeth 530

ILLUSTRATIONS—
Abdominal Tumours, Diagrams illustrating Dr. Taylor's Lecture on ... 166, 168, 169, 170
Arms of Guy's Hospital, The... 527
Guy's Smoking Concert 522, 524, 526

PAGE

ILLUSTRATIONS (*continued*)—
- Inter-Hospital Rugby Challenge Cup Final 143
- Opening of the Henriette Raphael Nurses' Home 299
- Pakes' Dinner Menu, The 33
- Portraits—
  - Miss Clemence M. Cotton 282
  - Patrick Thurburn Manson 139
  - Dr. Henry Oldham 505
  - Wordsworth Poole 74
- Stomach, Perforation of the, Diagrams illustrating Dr. Shaw's lecture on ... 432, 433
- Traumatic Fever, Charts of Temperatures 199, 200, 201

Influenza 1
- Bacillus 2

Inoculation, Dr. Amian's Practice of, in 1723 ... 52
In Lighter Vein—
- The Theatricals 15
- Mansion House Meeting 43
- Debating Society 61
- Programme of Farewell Concert 80
- A Research upon the Aetiology of Tinea Residentorum... 92
- Surprise Visit of the Warden 141
- A Guest of the Residents 173
- The Conversazione in the New Nursing Home 223
- At the Central Criminal Court 400

Inter-Hospital Sports 286
Intussusception, Five Cases of 476

Jacobson, Mr. W. H. A., On Gonorrhœal Arthritis 85, 105
Jamaica, The Lepers' Home in 70
Jew, The Barbary 283
Jones, Professor T., Medallion Portrait unveiled at Manchester 20

Laparotomy, Two Cases of, under Eucaine ... 354
Lavers-Smith, Mr. H., A Punch and Judy Show 72
LAWN TENNIS CLUB—
- Matches—
  - v. Gravesend 247
  - v. Harold 288
  - v. Kent 308
  - v. Wanstead 247
- Past v. Present 288
- Tournament Notice 267
- General Meeting 508
- Hospital Challenge Cup 308

Lectures for Session 1902–1903 379
L.D.S. Examination, Revised Syllabus for ... 323
- Notice of Examination 445

Lepers' Home, The, at Spanish Town 70
Letter, An Open 114
Literary Club, Proposed 133, 163
- Smoking Room, In the 527

PAGE

London University, Pass Lists ... 15, 83, 93, 476, 526
- Presentation Day at the ... 244
- Rogers' Prize, The 93

Lord Mayor's Appeal on behalf of Guy's Hospital 21
Lucas, Mr. R. Clement, on Glandular Tumours in the Neck 469
Lymphosarcoma in the Neck 469

Mansion House Meeting on behalf of Guy's Hospital 21, 43
Marach, a Surgical Dressing 242
Marriages ... 20, 84, 164, 184, 208, 268, 288, 308, 328, 348, 368, 395, 468, 488, 536
Mason, Mr. A. L., on Hypoplastic Teeth ... 530
Masonic Lodge, Proposed, at Guy's 32
Medical Heresies 97, 110
Medical Phonographers, Society of 20, 323
Medical Profession, The 323
Medical Wards, In the 262, 313, 476
Medicine for the Million 120
Medicine and the Motor Car 284
Medicine as a Profession 480
Medicines, Patent, Composition of Certain ... 112
Memorial, The South African, Fund 61, 178, 183, 196, 218, 225, 245, 254, 258, 288, 306, 416, 458, 486
- The Washbourn, Fund 437, 458, 478, 505
- The Wooldridge 324

Meningitis, Basal 126
- *Diagnosis of* 128
- Micro-organisms in 130

Mentality, Unconscious 529
Motor Car, The, and Medicine 284
Mouth-breathing, The Relation of, to Superior Protrusion 16
Museum, Guy's Hospital, State of the Surgical Pathological Section 91
Muscular Atrophy 329
Murchison, The, Scholarship in Clinical Medicine 74

Nurse, The, in Fiction 226, 527
- Nineteenth Century, The 242

Nurse's, An Institution, Letters from East Africa 403
Nurses' Choral Society, The 438, 529
- Home, the Henriette Raphael, Opening of 302

Nursing, Hospital, *The Nineteenth Century Review* on 185
Nursing News 20, 44, 80, 93, 158, 184, 258, 283, 306, 346, 358, 427, 487

OBITUARY—
- Dr. George Elliot Caldwell Anderson ... 174
- James Bankhart 462
- Sister Clemence Margaret Cotton 282
- Patrick Thurburn Manson 139
- Dr. Henry Oldham 505

PAGE

Obituary (*continued*)—
Wordsworth Poole 58
Edwin Stott 238
Major Sidney Offord Stuart 174
Dr. John Wychenford Washbourn 281
Maurice Dunbar Wood... 484
Odgers, Mr. P. N. Blake, B.A., On Traumatic Fever 199
Odol, an Analysis of 367
Officers' and Servants' Dinner 94
Old George Inn, The... 76
Oldham, Dr. H., Obituary Notice of 505
Ophthalmic Notes in Medical Practice 502
Ophalmometer, An Improved 82
Optic Neuritis, Illustrations of 355
Ossicles, The Tympanic, Caries of... 349
Ostrich, My First 362
"Our Ancestors' Certain Cure" 216
Out-Patients, Notes from 69
Tea Fund Balance Sheet 119
Oxford University Pass List 15
Plan of Examination for M.B. Degree 484

Pakes, Mr. W. C. C., A Send-off Dinner to ... 31
Farewell to... 61
Papers by Guy's Men 15, 30, 60, 71, 82, 113, 138, 144, 161, 181, 193, 225, 238, 253, 278, 298, 306, 328, 343, 354, 392, 441, 465, 508, 533
Paracentesis and Acupuncture, Some Notes on ... 49
Paralysis, Diaphragmatic and Vagus, Case of, after Diphtheria: Death 194
Passim 13, 33, 55, 75, 95, 115, 135, 155, 175, 197, 219, 239, 259, 279, 299, 319, 339, 359, 393, 417, 439, 459, 479, 499, 523
Pathologist, From the Gazette's Special 35, 64, 83, 101, 158, 184, 224, 248, 264, 326, 342, 422, 448, 498, 536
Pelvis, Contracted, A rare form of; difficult Cephalotripsy 401
Peritonitis, Acute General 269, 391
Local 391
Caused by Rectal Stricture 313
Tubercular 249
Pendred, Dr. Vaughan, Danger of the Douche ... 172
Cases of Thyroid Disease 444
Pharmacy in the days of old 216
Phonographers, Medical, Society of 20, 323
Physical Society—
Clinical Evening 498
Papers read before the Society—
Medical Heresies. By Mr. Owen Richards 97, 110
Acute Bright's Disease. By Mr. G. G. Davidson 139, 158
Traumatic Fever. By Mr. P. N. Blake Odgers 199
Hypochondriasis. By Mr. H. Barber ... 517

PAGE

Physiological Society—
Meetings 402, 438, 458, 529
Papers read before the Society—
Hypnotism. By Mr. P. R. Bolus 482
Unconscious Mentality. By Mr. H. O. Brookhouse 529
Pine Fibre 82
Pitt, Dr. G. Newton, Headaches and their Treatment 405
Poetry—
The Modern Dragon of Wantage 54
Sighing: To the Sex 222
Poole, Wordsworth, Obituary Notice of 58
Prescribing, The Art of 445
Presentations 19, 268
Prize Day, 1902 410
Prize, First Year's Dental Students' 254
Second 254
Junior Proficiency 222
Golding-Bird 222
Michael Harris 222
Practical Dentistry 254
Rogers 93
Wooldridge 222
Examinations for 1902 93
Proptosis 186
Punch and Judy Show 72
Purves, Mr. Laidlaw, Resignation of 219

Quack Medicines, some, Composition of ... 112

Raphael, Henriette Nurses' Home, Opening of the... 302
Rectum, Stricture of the 313
Red Line, The 356
Reviews—
Allchin, Dr.: A Manual of Medicine, Fourth Volume... 466
Bacteriology: Catechism Series 466
Ballin, Ada S.: From Cradle to School ... 225
Blumfield: Anæsthetics 466
Cheadle, W. B., M.D.: Artificial Feeding and Food Disorders of Infants 444
Cheyne and Burghard: Manual of Surgical Treatment, Part VI.... 263
Clodd, Edward: Thomas Henry Huxley ... 346
Cunningham, D. J., F.R.S.: Text-book of Anatomy 466
Dorland, W. A. Newman, M.B.: Illustrated Medical Dictionary 178
Fagge and Pye-Smith: A Text-book of Medicine 445
Gabell and Austen: Notes on Materia Medica, Pharmacology, and Therapeutics for Dental Students and Practitioners 347

PAGE

REVIEWS (*continued*)—
Gibson and Russell: Physical Diagnosis ... 367
Herter, C. A., M.D.: Lectures on Chemical Pathology 366
Husband, H. Aubrey: The Urine in Health and Disease 121
Hutchinson and Rainey: Clinical Methods 225
Jacobson, W. H. A., and F. J. Steward: The Operations of Surgery 263
Keith, Arthur: Human Embryology and Morphology 102
Lake, Richard, F.R.C.S.: International Directory of Laryngologists and Otologists 208
Lehfeldt, R. A., D.Sc.: A Text-book of Physics 367
Masterman, Arthur T., M.A., D.Sc., F.R.S.E.: Elementary Text-book of Zoology ... 347
Mercier, Charles, M.B.: A Text-book of Insanity 346
Nursing Guide, A 338
Paget, Sir J.: Selected Essays and Addresses 208
Practitioners' Guide 466
Pye and Carwardine: Elementary Bandaging 121
Rose and Carless: A Manual of Surgery ... 445
Royal Southern Hospital, Liverpool: Medical, Surgical, and Pathological Reports of ... 536
Smale and Colyer: Diseases and Injuries of the Teeth 120
Underwood, Arthur S.: Aids to Dental Anatomy and Physiology 444
Warwick and Tunstall: First Aid to the Injured and Sick 121
Windle, Bertram, F.R.S.: A Handbook of Surface Anatomy and Landmarks... ... 444
Richards, Mr. Owen, On Medical Heresies ... 97, 110
The Barbary Jew 283
Rifle Association, Season 1902 328
Royal College of Physicians of London, Pass Lists 193, 338, 476, 504
Royal College of Surgeons of Edinburgh, Pass List 194
Royal College of Surgeons of England, Notice of L.D.S. Examination 445
Royal College of Surgeons of England, Notice of Examination for the Fellowship 462
Royal College of Surgeons of England, Pass List 224, 306, 504
Royal College of Physicians and Surgeons and the Title of Doctor 218
Royal Navy, Notice of Examination 218
Rowlands, Mr. R. P., Revised Syllabus for the L.D.S. Examination 323

Sale of Work at Croydon in aid of Guy's Hospital 217
Sanitas Electrical Company, The 416

PAGE

Shaw, Dr. Lauriston E., In the Medical Wards ... 313
Notes from Out-patients 69
Perforation of the Stomach as a result of Cancer 429
Elected Secretary to the Faculty of Medicine, London University ... 483
Small-pox, Diagnosis of 65
Smoking Concerts 92, 523
Society of Apothecaries of London, Increased Examination Fees 93
Somewhat Lighter 481
South African Civil Surgeons' Dinner 245
Memorial Fund 61, 178, 183, 196, 218, 225, 245, 254, 258, 288, 306, 416, 458, 486
Stomach, Perforation of the, as a result of Malignant Growth 429
Students' Annual Dinner 423, 438
Students' Club, Annual Meeting 465
Students' Glee Club 438, 529
Sussex Elysium, A 343
Swimming Bath, Wilful damage to 438
Club, Annual Meeting... 164

Targett, Mr. J. H., Incomplete Abortion ... 45
Taylor, Dr. Frederick, Posterior Basal Meningitis 126
Addison's Disease... ... 145
Some Abdominal Tumours 165
Some Convulsive Disorders 229
Tempora Acta... 79
Tetany and Di-aceturia 40
Theatricals at Guy's Hospital 11
Things Reflected on 533
Thoracic Aneurysm 451
Thrombosis, Venous, in Heart Disease 371
Thyroids, Some 444
Tooth in the Larynx causes death while under an anæsthetic 419
Traumatic Fever 199
Tumours, Abdominal 165
Glandular, in the Neck 469
Tubercular Peritonitis 249
Types—1. The Amorist 19
2. The Actor 30
3. A Cultured Man... 53
4. The Man of Blood 82
5. The Man from South Africa 101
6. The Courtier 113
7. The Colonial 134
8. The Mediocre Man 162
9. The "Pro" 181
Typhoid Fever 36
Tyson, Dr. W. J., Ophthalmic Notes in Medical Practice 502

PAGE

United Hospitals' Annual Athletic Sports ... 286
Hare and Hounds 447, 468, 488, 535
University Degrees for Dental Students 489

Visick, Mr. H. C., The Relation between Superior Protrusion and Mouth Breathing 16

Wales, Prince of, opens the Henriette Raphael Nurses' Home 302
Walking Match, Great, in Germany 255
Wantage, The Modern Dragon of 54
Wards, Medical, In the 476
Wards, The, at Christmas 7
Washbourn, Dr. J. W., On Influenza 1
Typhoid Fever 36
Washbourn, Dr. J. W., Diagnosis of Small-pox... 65
Death of 259
Obituary of 281
An Appreciation of 304
Memorial Fund 437, 458, 478, 505
Wealth 485
White, Dr. W. Hale, On Tubercular Peritonitis... 249
Acute Peritonitis 269
Diabetes 289
Venous Thrombosis in Heart Disease 371
Thoracic Aneurysm... ... 451
Malignant Endocarditis ... 510
Wooldridge Memorial 324

Young, Advice to the 277

Contents.

	PAGE
INFLUENZA: Clinical Lecture by Dr Washbourn	1-7
CHRISTMAS WEEK	7-11
THEATRICALS	11-12
PASSIM	13-15
PASS LIST	15
PAPERS BY GUY'S MEN	15
IN LIGHTER VEIN	15-16
A CONSIDERATION OF THE RELATIONSHIP BETWEEN SUPERIOR PROTRUSION AND MOUTH-BREATHING ...	16-19
TYPES	19
NURSING NEWS	20
THE SOCIETY OF MEDICAL PHONOGRAPHERS...	20
APPOINTMENTS	22

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

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Calendar of Coming Events.

January, 1902.

Sat. 4.—Messrs. Jacobson and Fripp's take-in; Drs., S. E. Pallant and W. L. M. Day; Cl., S. Hodgson.
G.H.R.F.C., I., Old Leysians, home.
III., Blackheath School, away.
G.H.A.F.C., I., Old Eastbournians, home.
II., Woodford Albion, away.

Wed. 8.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.A.F.C., II., St. Thomas 2nd XI., home.

Thur. 9.—Messrs. Howse and Symonds' take-in; Drs., C. F. Fraser and W. W. Read; Cl., H. C. Keates.

Sat. 11.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Catford, away.
II., Rosslyn Park II., home.
G.H.A.F.C., I., Townley Park, home.
II., Kenley Reserves, away.
G.H.P.P.S., Clinical Meeting.

Mon. 13.—1.15 p.m., Clinical lecture by Dr. Galabin.

Wed. 15.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.R.F.C., I., Royal Naval College, home.

Thur. 16.—Messrs. Lucas and Lane's take-in; Drs., W. Strange and B. H. Wedd; Cl., P. N. B. Odgers.

Sat. 18.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Rosslyn Park, home.
III., U.C.S. Old Boys "A," away.
G.H.A.F.C., I., Beckenham, home.
II., Beckenham 2nd XI., away.

Guy's Hospital Gazette,

JANUARY 4, 1902.

Influenza.

CLINICAL LECTURE BY DR. WASHBOURN.

December 14th, 1901.

GENTLEMEN,—To-day I propose bringing before you several cases of Influenza which have come under one's notice recently. The first two cases I had not an opportunity of seeing during life. In conjunction with Dr. Eyre I was investigating the bacteriology of pneumonia, and two lungs were usually sent to us from patients who were supposed to have suffered from ordinary bronchopneumonia during life. In both cases we found, on examining the lungs, that the influenza bacillus was present in the pneumonic areas. In one case it was present alone; in the second case it was associated with the pneumococcus. The one case was that of a child about four years of age and the other was an infant under one year.

The bacteriological diagnosis of influenza is often of great utility, and you can frequently find by examining the sputum or the lung after death, that the case is one of influenza.

The *influenza bacillus* is a very minute organism. It is much smaller than the other pathogenic bacteria, and it has this peculiarity, that it stains at each end, but remains unstained in the middle. Being exceedingly minute and staining only at the two ends, it looks very much like a diplococcus. Under certain circumstances the bacilli grow out into short chains consisting of several individuals. The bacilli do not stain readily with the ordinary stains used for other bacteria. The best method is to use a weak solution of carbofuchsine, about 1 in 12, and to stain for a quarter of an hour or twenty minutes.

The influenza bacillus is by no means easy to cultivate, for it does not grow on the ordinary media. The best medium is agar upon which human blood has been streaked. Animal blood will also serve the purpose, but not so well as human blood. Upon such a medium the influenza bacillus forms very minute transparent

colonies, and an important characteristic is that these colonies quickly die. You know that many pathogenic organisms remain living in cultivation for a long time, such as the anthrax bacillus which can live for many months, but the influenza bacillus dies in about twenty-four hours. In order, therefore, to keep cultivations going you have to make fresh cultivations every day. This is, as you will see, a great matter in regard to the etiology of the disease. You will see, from what I have told you, that the influenza bacillus is not likely to lead an independent existence outside the body of animals. In correspondence with that, there is every reason to suppose that the disease generally spreads by direct contact from one individual to another, and that it is not conveyed by means of water, or dust, or in any of those ways which are important factors in the spread of other diseases, such, for instance, as typhoid fever.

The influenza bacillus is not pathogenic to animals. We do not know any example of animals being affected with influenza, nor is it possible to successfully inoculate animals with the bacillus.

The proof that the bacillus is the cause of the disease is the fact that it is found very often in large quantities in cases of influenza, and is not found in other diseases. It is most easily found in cases of what I shall deseribe to you as the bronchitic type of influenza. In such cases there is marked bronchitis, and the sputum often contains an enormous number of bacilli, which can be demonstrated by cover-glass preparations or by cultivation.

An interesting point in connection with the influenza bacillus is that it is present in the bronchial secretion for a long period after the patient has become convalescent. Perhaps you will remember that the same occurs in connection with typhoid. In many cases the typhoid bacillus remains living in the intestines and in the gall-bladder for a long period after the recovery of the patient. This fact is of importance in connection with the spread of the disease, for it explains how an individual who is perfectly well may convey the disease to others.

Influenza has occurred in different countries in the form of very widely spread *epidemics*. There have been a number of epidemics described in England. There was one in 1837, the next occurred in 1847, and then for a long period after that there was no record of influenza. Whether sporadic cases occurred in the interval we do not know, but certainly there was a large epidemic of the disease in 1847, and the next outbreak took place in 1889.

I remember one of the earliest cases that occurred in 1889. The disease was then, of course, new to most of us. The case to which I refer was that of a medical student who was attacked suddenly with pyrexia, a temperature of 104°, very severe pains in the body, and profuse perspiration, and he was exceedingly depressed. We could not make out what was the matter with him. After some few days his temperature went down and he slowly recovered. It was only subsequently, when other cases occurred, that we were able to recognise this as a case of influenza.

Since 1889 the disease has always been with us, and I have seen several cases recently. Here is the case of a patient, seven years old, in the London Fever Hospital. He was admitted on the 12th November for an ordinary attack of scarlet fever. He convalesced and was getting on perfectly well until December 2nd. Then he began coughing incessantly, his temperature was 103·2°, the respirations were rapid and irregular, about fifty per minute, the cough was dry, the alæ nasi were working, the pulse was 136 and regular, there was no vomiting, nor rash, nor adenitis. The first thing one thinks of in a case of convalescent scarlet fever, when the temperature rises, is that there is some complication of scarlet fever commencing, such as adenitis or nephritis. The lungs were resonant, there were scattered crackling crepitations all over, and almost bronchial breathing beyond the normal area in the interscapular region. The heart sounds were clear, and there was nothing abnormal to be made out in the abdomen. Then there is this note: "Several patients have had cough, and one bronchopneumonia, coming on very acutely and severely, accompanied by severe abdominal pain." The

temperature was 103° on the second day, 102° on the third, on the fourth it was just about normal, and on the fifth day it had become normal, and the patient was convalescent. Here was an instance of a patient convalescent from scarlet fever, who suddenly was seized with coughing and high temperature and signs of bronchitis. In two or three days the temperature went down and the patient was convalescent. We diagnosed that as a case of influenza, because there had been other cases in the ward which were of this nature.

The next case is that of another patient who was convalescent from scarlet fever, a child four years of age. The scarlet fever went on in the usual way. He was admitted on the 13th October, and on November 23rd, well on in convalescence from scarlet fever, there is this note: "The boy has been rather depressed for the last few days. To-night he went to bed apparently well, but at 1.30 in the morning his temperature was 104·8°; he looks very ill, pale and anxious, the respirations are 48, pulse 140, he complains of pain in the abdomen, the lungs are resonant, the breath sounds are very loud, the heart is normal, the abdomen is a little full and moves actively—it is slightly tender on the right side, but not in the iliac fossa. The throat is normal, the tongue clear, no adenitis, no pain or tenderness about the ear." It was thought that the patient might have a mastoid abscess coming on from otorrhœa. The next day there were some scattered crepitations at the bases of the lungs. On the following day there was some impaired resonance over both lungs, and bronchial breathing was heard here and there. The temperature all this time kept up. The next day the respirations were still very rapid, and there were signs of consolidation in the left base and left axilla, and also many consonating râles. The breathing was difficult at night, and on the day following there was consolidation up to the apex of the lung. After this had gone on for a week, the patient's temperature came down to normal, and he began to convalesce. This was a case of the bronchitic type of influenza, which passed on to pneumonia.

There is another case, in Clinical, a little girl whom I think I mentioned last time as having had pneumonia on several occasions. She was admitted here in 1893 with bronchopneumonia, in 1895 for pneumonia, in 1896 for lobar pneumonia, in 1898 for right apical pneumonia, and in 1899 for pneumonia over the whole of the right side. On the present occasion she was admitted into the hospital for sickness, headache and cough. On admission she had pyrexia, the temperature being 102°, which lasted for seven or eight days. During that time she had signs of consolidation of the lung, which were somewhat indefinite. The consolidation was not absolute; there was not absolute dulness, with loud bronchial breathing, such as you generally get in ordinary lobar pneumonia. She was more prostrated and her pulse was more rapid than one would have expected from the condition of the lung, had it been a case of ordinary pneumonia, from which we inferred that she was suffering from influenzal pneumonia, although on examining the sputum we were unable to detect the presence of influenza bacilli. Her temperature gradually came down, not by crisis as you usually get in lobar pneumonia, but by lysis, and the patient is now convalescent.

There is another case that I might mention to you, a child of seven months old whom I saw the other day. This baby had a temperature of 104°, lasting for a week, she had rapid breathing and a rapid pulse, but nothing else was discovered. A day or two later the child developed lobar pneumonia. That I believe to be a case of influenza which was followed by lobar pneumonia.

The first of these cases was a simple case of influenza, the second was a case of influenzal pneumonia, the third case was apparently of the same kind, and the fourth was a case of influenza which was complicated by pneumonia. I shall shortly draw your attention to the difference between pneumonia complicating influenza and the ordinary influenzal pneumonia.

The *incubation period* appears to be very short, probably only a day or two. That is why the disease spreads exceedingly rapidly in epidemics. The onset of influenza is characterised by its suddenness. This was especially marked

in the early cases that occurred in the 1889 epidemic. A gentleman told me that he was in his garden one day in the summer of that year, and he was called in to tea. He started to walk into the house when he was suddenly seized with most acute pain in the back, he felt very ill, and had to be helped up to his bedroom. He had been perfectly well just before that. One does not now, as a rule, meet with such characteristic cases as one used to meet with in the early part of 1889. Not infrequently influenza comes on more or less insidiously, especially in the mild cases.

You can divide up influenza into several types. The main types are: the febrile type, the bronchitic type, the gastro-intestinal type, and the cerebral type. You will find that in different epidemics one or other of these types is predominant.

In the *febrile type* the main features are the following. The patient is seized with severe pain in all parts of the body. Pain in the back is very characteristic, also pain in the limbs and in the back of the eyes. With the pain there is pyrexia, which may be 104° or 103°. The patient very frequently perspires freely, and that is sometimes a characteristic symptom. The respirations and pulse are both increased in rapidity; the respirations especially are often increased out of proportion to the temperature. There is generally a great deal of mental depression. For instance, I remember a case of a gentleman who was spending the evening with some friends, playing cards, and when feeling perfectly well, was suddenly seized with most severe mental depression. He went home and had a well-marked attack of influenza. The mental depression was the starting-point of the attack.

There is often a certain amount of inflammation of the throat, not, as a rule, very severe, but still the throat is dry and painful, and on examination it is found to be slightly inflamed. This is of some interest, because it is probable that in these febrile cases the bacilli enter by means of the tonsils. The attack lasts usually only a few days in uncomplicated cases, the temperature comes down, and the patient slowly convalesces.

One marked feature about influenza is the slowness of the convalescence.

In the *bronchitic type* you get the same kind of symptoms as in the febrile type, but in addition to those symptoms there is a marked bronchial affection. The breathing often is exceedingly rapid, so much so that you think the patient is going in for pneumonia. I recollect the case of a young lady who was supposed to have lobar pneumonia, the diagnosis being made chiefly upon the high temperature and exceedingly rapid breathing. There were some râles in the lungs scattered over both bases. The case proved to be one of influenza.

There is sometimes an enormous quantity of expectoration. I remember the case of a gentleman who went to bed perfectly well. In the middle of the night he woke up with a cough, and expectorated an enormous quantity of glairy mucus; he filled a basin about the size of an ordinary washing-basin half full of expectoration during the night. In the morning the cough ceased, and he slowly recovered, but it was a long time before he got quite well.

The expectoration varies in its character. One feature is that it is very sticky, a glutinous expectoration, not rusty, but sometimes tinged with blood. Not infrequently you find in the sputum little yellowish-green pellets which contain almost always a large number of influenza bacilli. With the cough there is pain in the chest, and a feeling of suffocation and depression about the chest.

The chief way in which you can distinguish a case of this sort from ordinary bronchitis is the extreme prostration. In the bronchitic type of influenza the patient is much more ill than one would expect him to be from the condition of the lungs. Not infrequently in bronchitic influenza arises bronchopneumonia. The inflammation passes from the bronchi down into the lungs, and then you get an influenzal bronchopneumonia, such as occurred in the second case, the notes of which I read to you. This influenzal bronchopneumonia differs a little from ordinary bronchopneumonia, chiefly in that the patches of consolidation tend to run together so as to involve the whole of one lobe. As a rule, the lung is not completely solidified, and

there is not the complete dulness or such marked tubular breathing as in ordinary lobar pneumonia.

Another characteristic of influenzal pneumonia is that it creeps from one parts of the lung to another; it clears up in one part and appears again in some other part of the lung.

In some of these cases there is laryngitis. A gentleman was taken ill with fever, laryngitis, and very marked bronchitis; he coughed up a large quantity of glutinous expectoration which was slightly tinged with blood. The diagnosis of influenza was made on account of the extreme prostration. The patient was much worse than one would have expected in an ordinary case of laryngitis and bronchitis. Unfortunately the diagnosis was proved to be correct, the case terminating very rapidly fatally.

Another type is the *catarrhal type*, in which the particular symptoms are those of nasal catarrh, with the patient much more ill than in an ordinary case of nasal catarrh. I am thinking now of a case which was supposed to be an ordinary case of catarrh, but the patient seemed worse than one would expect, and he took a long time to recover from the illness. In that case influenzal bacilli were found in the nasal expectoration. These catarrhal cases frequently pass into the bronchitic type. The fauces are often inflamed in both types.

The *gastro-intestinal type* is by no means common, but it occurs from time to time. In this type the symptoms are colic, vomiting and diarrhœa. There are some cases in which the diarrhœa is very watery and not at all unlike cholera.

There is another type which is only a part of the febrile type, and which is called the *cerebral type*. In this type there is high fever, marked stupor, headache and delirium, and in some cases actual meningitis is found.

The last type of cases are the *mild* cases which begin, as a rule, insidiously, and it is only perhaps by the onset of some complication or because there is a good deal of mental depression, that they are recognised.

In all these types of cases there are certain features which are common. The tongue, as a rule, is coated with white fur and the breath is very offensive. Another common feature is pain—pain in the back, at the back of the eyes, in the limbs, sometimes in the joints, in the bones—pains, in fact, in almost any part of the body. These pains are especially severe. Pyrexia occurs in almost all the severe cases, and in most of the cases the pyrexia is continuous, but not infrequently you get rigors, these being associated with marked perspiration; so that in some cases you are doubtful whether you are dealing with a case of influenza or one of malaria. The perspiration is generally of a very offensive and peculiar character, so much so that many people think they are able to diagnose influenza by the odour of the sweat. In some cases, the perspiration is most extreme; the bed is simply drenched. I remember one case of a gentleman who had to have the whole of his bed-clothes changed two or three times a day on account of the perspiration. Mental depression, too, is a very marked feature of influenza, and sometimes it is very severe. The patient takes no interest in anything, and everything appears black and gloomy. That occurs not only with adults but also with children. The influenza toxine obviously has a marked effect upon the higher cerebral centres; another point is that convalescence from influenza is slow. Many patients say that they have never got over their first attack of influenza.

Now with regard to the complications. A complication of some interest in connection with influenza, although not a common one, is the occurrence of a rash. In some cases there is a scarlatiniform eruption not unlike that of scarlet fever; in others a macular eruption not unlike that of measles; in some cases there is a purpuric eruption, while in other cases herpes occurs especially in the bronchitic type. In connection with purpura, hæmorrhages sometimes occur from the mucous membrane of the mouth, the uterus, etc. In the bronchitic type there may be profuse hæmoptysis, which may be mistaken for the hæmoptysis of phthisis. Much more common complications are those connected with the lungs. I have already mentioned to you that in the influenzal pneumonia which occurs during an acute attack of

the bronchitic type, the inflammation passes down from the bronchi into the lungs, but an ordinary lobar pneumonia not infrequently comes on during convalescence or during an attack of influenza. I mentioned the case of a baby who had a temperature for seven or seven or eight days, and then lobar pneumonia had started. That was a case of ordinary lobar pneumonia which had arisen as a complication of influenza. Such a lobar pneumonia is exactly the same in character as ordinary lobar pneumonia, with this difference, that the mortality from it is higher.

In connection with the lungs, there is not infrequently pleurisy, and sometimes an empyema.

The nervous system is especially affected. I have already pointed out that mental depression is a common symptom; sometimes it goes on into actual melancholia. Hence, during an epidemic of influenza there is an increase of cases of melancholia in the asylums. Insomnia is often a symptom of influenza. The pains which occur during the febrile stage may continue or recur during convalescence. There is also frequently neuralgia in various parts—sometimes in the face, sometimes in the limbs. I know of two instances, both of which occurred in medical men who, during convalescence from influenza, suffered from severe rectal neuralgic pain. In both cases the pain came on in the same way. The patient awoke up in the night with severe pain, so severe that in each case he thought he was going to die. In one case the pain subsided by the next day, in the other in a day or two.

Neuritis sometimes comes on after influenza, a neuritis which has no very definite characteristics. It may attack almost any nerve.

There are certain cardiac symptoms which may arise. The heart may become dilated. Not at all infrequently there is tachy-cardia, this condition lasting for some months after an attack of influenza, so that an influenzal heart used to be talked about. Sometimes the patient faints easily. Sometimes anginal attacks come on after influenza. In a few cases there is endocarditis; it is generally an infective endocarditis due to secondary invasion by other bacteria, but sometimes it seems to be due to the influenza bacillus itself.

In connection with the circulatory system you sometimes get phlebitis, just as you do in typhoid.

There are a number of acute suppurative affections that may arise. I remember one gentleman who had a prolonged attack of bronchitic influenza, during which he developed a little swelling underneath the skin over the thyroid body. That subsided and then a similar condition arose in the leg, which likewise subsided, afterwards he developed another similar condition in the abdominal muscles, which suppurated, the pus containing streptococci.

In some cases tuberculosis follows upon influenza, and influenza is always a serious condition in tuberculous patients, causing latent tubercular processes to start into activity. For instance, at the time of the epidemic of 1889, it caused a great deal of damage in various sanatoria for phthisical patients.

There are a few other conditions that may arise, such as orchitis, arthritis, conjunctivitis and other affections of the eye. Sometimes an enlargement of the spleen occurs which may render it difficult for you to diagnose between influenza and typhoid fever.

With regard to protection, relapses are very common, and one attack only protects for a short period. In fact, many patients appear to be more liable to the disease after the first attack than before. A number of patients have had a dozen or twenty attacks of influenza.

With regard to diagnosis, I will mention one or two points. You may easily mistake influenza for commencing pneumonia; the rapid breathing and high temperature may render the resemblance close. It is sometimes absolutely impossible, in cases of so called latent pneumonia, to be sure whether the attack did not begin as one of influenza upon which pneumonia supervened, or whether it was a pure case of pneumonia. In a prolonged case you may mistake influenza for enteric fever, and you must be guided chiefly by the condition of the spleen, by the spots, and by the Widal reaction. During the first day or two it may be doubtful whether one is dealing with some other infective fever, such as variola.

Influenza with a rash is sometimes difficult. For example, you may mistake a case with scarlatiniform eruption for scarlet fever, or a case with morbilliform eruption for measles. These cases you must diagnose chiefly from the absence of the ordinary signs of scarlet fever or of measles, as the case may be.

Christmas Week.

WARD DECORATIONS.

The most noteworthy feature of the decorations this year was the almost universal use of electric lights. Although the keenness of the good-humoured rivalry existing between the different sisters was somewhat dulled by the general plan of the decorations being decided by the wires of that band of hard-working electricians—to whom all thanks are due—the ingenuity of the several workers succeeded in producing that "infinite variety" so dear to the artistic nature. The eye that was dazzled almost to blindness by the massing of brilliant red lights down the centre of Dr. Hale White's division of PHILIP, was quickly soothed by the softer effect obtained by Chinese lanterns in STEPHEN.

The many divisions of MARY presented a picture of most artistic completeness; a crayon portrait of Dr. Perry at once caught and held the eye.

The decorations in OUT-PATIENTS were worthy of the splendid concert given in the Banquet Hall; more cannot be said.

All the Surgical wards showed a most artistic conception of what Christmas decorations should be like; the green arches gemmed with coloured lights called forth repeated exclamations of praise from visitors entering LYDIA.

Having to rely on the now primitive fairy lights for illumination, seems to have stimulated the artistic sense of workers in JOB and PATIENCE, producing an effect at once pleasing and unique.

The visitor to LUKE was met by the apt and characteristic words "Luke, my Dear" and "Bless the Boys" done in coloured lights.

Taking the Wards, one and all, they have never looked better, and as we have already intimated, not a little of this is due to the splendid way in which the hospital electricians worked.

THE NIGGERS.

Christmas-day found the Niggers once more on their tour through the wards. After many weary weeks of practice, they were at last in training for their gigantic task. Mr. Wacher had undertaken the conductorship, and to him a great deal of the credit is due for the Father O'Flynn-like way in which he coaxed uneasy ones, and lifted lazy ones on with a stick. Mr. Larkin accompanied throughout the day, and rendered most able assistance.

The costumes were many and varied and baffle description. Dr. Bruce appeared as a tramp labelled "Totally Blind," and his appearance was a thing of beauty and a joy for ever. There were sailor lads of different sorts, military men, veterans, and so on. Wigs there were of many a hue, also beards; one we noticed particularly, a red Dundreary pattern tied with blue ribbon bows, ornamenting Mr. Brydone. There was a beautiful Mephistopheles costume with movable ears, by D——— & Co., Costumiers, a perfect creation, and lastly Mr. Pallant appeared as a young lady. His costume of white with red baby ribbon, the clocked stockings and high shoes, the early Victorian hat with red roses, all showed the care that had been lavished on the debutante.

The wind found many an undefended space while the troop was waiting on the colonnade steps for the photographer, and everyone gaily followed the President into the Eye wards, where the day commenced, and passing on through the Medical wards came to Out-patients, after welcome refreshments in Mary and Bright. A perfect howl of delight, mingled with a certain percentage of fear, hailed the advent of the troupe, who marched Indian file around the hall, and in one of the charming little sitting-out rooms found whisky and cigarettes, and held a well-earned halt. Once more around the Out-patients amidst deafening noise and many appreciative hands, and then out into the Park. A halt in Clinical after a short turn in each ward, and then that friendly resting place—the Clinical's room—with welcome bovril, whisky and cigarettes and so on.

Once more on again to Patience and away through the Surgical wards, well up to time in spite of a few extra items, and into Job. At last Mr. Gibson's top note met with true appreciation, and he was warmly congratulated by the corner men. More tea and refreshment, which was badly needed as strength was fast leaving us. Cheered by the sight of the harbour lights in Astley Cooper, everybody made a grand final effort, and sang the National Anthem. A sigh of relief from the whole troupe, a rush for hot water in the College, and in an hour a party of moderately respectable, though tired-looking gentlemen, did justice to the going-off dinner.

THE MEDICAL WARDS CONCERT.

The people of Guy's are a conservative folk, and when rumours spread abroad that startling innovations were expected this Christmas on the medical side in the matter of the giving of concerts, tongues were wagged and heads shaken with ominous deliberation. A united Medical Wards Concert!—obviously doomed to failure—place much too small, besides, how on earth are they going to cart down all their wretched medical cases to bleak out-patients?

However, time passed, and a fresh eruption of rumours having appeared, people began to realise that the affair was going to be a brilliant success. Hence, on Friday, December 27th, at 4.30 p.m., they trooped in their tens and their hundreds to—not a bleak out-patients, but a hall full of light and warmth and luxury. Their feet sank

ankle-deep in rich carpets from the Orient, and the soft glow of innumerable lights, pendant from gracefully-swung festoons, made every lady's complexion put the damask rose to shame. And the refreshments! One at last realised that it was of the Medical Wards Concert that Keats was dreaming when he sang of—

Jellies soother than the creamy curd,
And lucent syrops, tinct with cinnamon.

Indeed, we did hear one enthusiastic Institute Nurse declaim that she had consumed three absolutely new sorts of sandwiches, and each one melted in the mouth faster than the last—teeth were superfluous.

Yet all this was merely by-the-way, passim—the rich setting of the precious stone, the Concert. To begin at the beginning of the concert programme and work stolidly through, detailing all the items, were even duller than to print the programme itself without comment, but at the very beginning we must begin, for the first performer was Miss Tschaikowsky, and she started the concert on the right road with her dainty singing. Mr. Ward amazed everyone by the facile command he had over his instruments, whether his brilliantly tuned piccolo, or his soft and mellow flute. For the afternoon the Savoy parted with three of its most charming ladies, and Miss Isabel Jay and Miss Evelyn Bond delighted all ears with their finished singing, while Miss Maud Thornton accompanied with sympathetic touch. Miss Jay's Irish songs especially appealed to all hearts; they were given with so clever a blending of pathos and humour.

Many in the room remembered Mr. Rohan Clensy's playing of last year, and richly he deserved the burst of applause that arose when he finished his solos. Mr. John Le Hay appealed to other emotions, and kept the audience in roars of laughter with his mermaid song. Unfortunately he had to leave early, but we had Mr. Priestley Tate and Mr. Corbett Smith to entertain us—the one with his rousing songs, the other with his Chevalier sketches, some pathetic, some comic. Which of us would not wish to hear Mr. Tate's "Jolly Jenkins," and Mr. Corbett Smith's "Mary had a little lamb" again? Madame Bertha Moore held everyone spell-bound while she sang her songs with remarkable feeling, and Mrs. Marzetti caused much disappointment when she had to hurry off without allowing us to hear her voice a second time. A delightful variation from the songs and solos was offered by Miss and Master Huth, who in pretty last century costumes, sang a duet and danced a minuet.

LAZARUS CONCERT.

This concert took place at 5 p.m., on Saturday. The distinguishing feature of the entertainment was the excellence of the artistes. Mr. Seymour Dicker, sometime organist of Brisbane Cathedral, opened with a particularly good pianoforte solo. He was followed by Mr. C. L. Phillips, who delighted his audience with Raff's Seronata. Mr. Phillips' excellent command over his violin is only equalled by his happy choice of music. Mr. Sivey Levey evoked shouts of laughter with his Hindustani Love Song. A very pretty song was the next item on the programme, which Miss Hilda Jackson rendered most charmingly. The name of Mr. J. A. Bovett is enough in itself to guarantee excellence, but he surpassed himself in his rendering of Richardson's beautiful song "Mary." Rarely has it been our good fortune to hear such singing in the wards, certainly never have we been present at better. As an encore he gave Loch Lomond. Mr. Wellbeloved gave a humorous selection in his inimitable style. The phonograph finished the first part, after which an interval for refreshments followed. During the interval the decorations were admired, the general opinion being expressed that they were the best in the hospital. The concert was continued with a rapturous rendering of Listz's Op. 52, by Miss Marguerite King. Miss Hunter, who has a very fine contralto voice, sang beautifully, and as an encore gave "Wipe those tears away." Messrs. C. L. Phillips, Sivey Levey, J. A. Bovett and Wellbeloved again performed, and were severally encored. "God save the King," and a vote of thanks to the artistes, came all too soon and put an end to one of the most enjoyable ward concerts it has ever been our pleasure to be present at.

LUKE CONCERT.

This concert, as usual, was a huge success, as shown by the number of encores given, and by the fact that after the first few turns there was "standing room only."

The programme was commenced with a pianoforte solo by Mr. Larkin. This was followed by a humorous sketch by Mr. Tom Clare, which was very well received. The programme was then enriched by the addition of an excellent violinist, Miss Ivy Angove, who was most tastefully accompanied by Mrs. Angove. Her performance of Hubay's "Hegri Kati" was so much appreciated that an encore was called for. One of Sir Henry Bishop's favourite songs, "Should he upbraid," was then rendered by Miss Parry with excellent effect.

Although we have heard "I want to join the Military," many times in various places during the last week, we have certainly not heard it more effectively rendered than it was at this concert by Mr. J. Atkins. Mr. James Avon, by the title of the song he had chosen to sing, "Am I in the Way," evidently wondered whether he was intruding on our musical gathering in Luke, but the applause, and desired encore, which was granted, plainly showed that he certainly was not in the way. We hope he will be with us again.

A little instrumental music was now provided in the shape of a banjo duet by Messrs. S. Williams and R. Constantine. Matthew's "May Day" was next sung by Madame Wilson Osman, with pleasing effect. A little Irish fun was now introduced into the programme by the appearance of Mr. R. Constantine, who delighted the audience with "The Ballymoney Conversazione." The first part of the programme was now concluded by some sleight of hand by Mr. John Warren. There was then an interval, during which tea was served.

The concert was resumed by the second appearance of Messrs. S. Williams and R. Constantine with a banjo duet, which as before was very much enjoyed. Mr. Tom Clare then came on the platform and gave us a most laughable sketch—loud and long applause; this of course resulted in an encore. A song by Miss Alice Parry followed. We were fortunate in having besides the musical talent present, a ventriloquist. Mr. Warren convulsed the audience with his imaginary dialogue which followed between himself and Marmaduke, his black doll; it ended with Marmaduke being put in the bag and taken home screaming. Messrs. James Avon and Tom Clare wondered whether they could manage a song between them, so they sang a duet entitled, "I think we can manage it between us," which they certainly did; further, the audience would not allow them to leave the platform without giving an encore. This was followed by a dramatic sketch by Mr. Well-beloved, with appropriate accompaniment by Mr. Larkin. As an encore to this he gave a humorous sketch about black boots and boot blacks.

Madame Osman again sang with her previous success. Mr. Avon this time thought he could manage a song by himself, so he gave us "There's 'Air," which was so much appreciated that an encore followed. It is rare for us to have the chance of listening to such an artiste as Miss Ivy Angove, and we were delighted to hear her a second time, an encore was again granted. The last item of the programme was given by Mr. Constantine, in his humorous song, "The Lady's Penny Paper," and the applause which followed was cut short by

"God Save the King."

CORNELIUS CONCERT.

This annual festivity took place on December 28th, at 6 p.m., amid surroundings which in no way disgraced the efforts of former years, and in spite of the counter-attractions of Lazarus and Naaman, the entertainment seemed to be as popular as ever, and the ward was stretched to its utmost limits. The performance itself was most excellent in every way, and it would be impossible to discriminate under conditions where all were of the best.

The instrumental part of the programme was supplied by Mr. and Mrs. P. Watt and Miss Barkrum in their trios for violin, 'cello, and piano, and by the Misses Blower and Glenn on the piano; of the above special mention of "Salut d'Amour" may be made. Mrs. Castle, and the Misses Spain and Daniell, ably maintained the reputation of the fairer sex by giving several delightful songs. Mr. Parrot appeared as an old friend and sang "The Yeoman's Wedding" in his own inimitable style. Much amusement was caused by Mr. Beck's recitation of his "Goose Araminta" and Mr. Oldershaw's song of the "King of Otahiti." Some of the most popular items were the songs with choruses given by Mr. Peel Yates and Captain Daniell. With these a most excellent performance came to an end. Everyone seemed to have enjoyed themselves immensely, and without doubt the M.C. (Mr. Glenn) and his fair assistant may be congratulated on their production.

CHARITY CONCERT.

This entertainment was given on Friday, December 27th, and as the ward was chiefly occupied by children, the major portion of the programme was devoted to a Punch and Judy show, which, though perhaps erring on the side of length, gave universal delight. Of the musical part of the programme, the best item was the dance, artistically performed by the Misses Olive Palmer and Ruth Lacey, whilst Mr. S. and Miss E. Chutter gave several delightful songs, of which the duet "Prithee Pretty Maiden" seemed to be the most appreciated. Mr. Fred Burrows caused much mirth by his song "When Father laid the Carpet on the Stairs." The ward was prettily decorated, the comestibles were of the best, and both seemed popular and drew large crowds. And those who were responsible for the afternoon's amusement may be congratulated on their effort.

DORCAS CONCERT.

Although taking place at the same time as Charity, the crowded ward gave testimony to the quality of the concert. The warm colouring of the electric lights added to the beauty of the decorations, which themselves were of the daintiest variety. The local talent was much added to by many well-known professionals. Miss Thekla Lillhardt played a brilliant piano solo, and then Mr. Wyatt sang "Fare thee well," in fine style. The place of Mr. Herbert Clayton, who, at the last moment was unable to appear, was filled most ably by Miss Isabel Jay from the Savoy theatre—who sang most brilliantly "When Jack and I were children," which was received with great applause. Miss Florence Jamieson's song was much appreciated. Mr. Ray Edridge recited "The Bishop and the Caterpillar," which caused much amusement. For those who delight in the classical, their tastes were amply satisfied by the magnificent playing of Miss Lillhardt on her violin. Miss Spenser sang some selections out of "Little Christopher Columbus." Mr. Gill gave some reminiscences of an American's ideas of Rubenstein. One of the features of the evening was Miss Lily Hanbury, who recited most charmingly "Riding thro' the Broom," and so much was she appreciated that she kindly gave as an encore "Where did you come from, baby dear?" Mr. Ransford ably entertained the patients with the never-to-be-tired-of gramophone. Mr. Winckworth was a most popular addition with his violoncello, on which he played "Un Rêve d'Amour" divinely. The evening concluded with a pianoforte duet by Miss Williams and Miss Philpotts. Thanks are to be given to Sister for her untiring efforts in making the concert such a success.

MARTHA.

The Christmas Tree in Martha this year was even a greater success than in former years. The children, about seventy in number, received quite a plethora of presents from the ever popular Father Christmas, who

was well represented by the versatile Mr. Cross. So enthusiastic did the children become that they would not leave until the tree had even been despoiled of its gaudy ornaments, which they hoped to use on their own little Christmas trees next year. Each ward sent its own contingent dressed in a special uniform, those from Lazarus and Lydia being conspicuous. During the distribution of buns and tea, a recitation, a gramophone and some incidental music were kindly rendered by some of those present.

NAAMAN CONCERT.

The concert in this ward took place on Saturday, December 28th, at 6 p.m. The excellency of the programme rendered the entertainment one of the most successful of the season, the charming decorations and the soft light of the fairy lamps lent their aid in making it so. Though there were some disappointments the vacancies were amply filled by Mr. J. E. Bovett, whose splendid tenor voice and his singing of "Mary" was one of the features of the evening. Mr. Atkins' "Military Man" was received with great enthusiasm. The comic element was supplied by Mr. Wacher, who sang "Maud" in his characteristic style, and Mr. Julier gave us some very funny items. Mr. Winckworth excelled himself on his 'cello, and Mr. Black caused much amusement by his playing of "Lucy Long" on the bassoon. Mr. Ray Edridge gave a good recitation from David Copperfield. Miss Beste, the ever popular favourite of the patients, sang a solo and also a duet with Mr. Wise. Mr. Leaf Wright sang "When I was a Boy at School" and the "Deathless Army." Sister is to be congratulated on the admirable arrangement of the patients, who heard and saw everything.

LYDIA CONCERT.

This concert took place at 5 p.m. on Monday. Although four professionals were unable to come at the last moment, owing to throats and colds, still a good many did turn up. Mr. Gerald Ticehurst opened with a piano solo; then Mr. Morten H. Cotton enlivened everybody, especially the children, with a musical sketch, and later on gave some very laughable comic songs. Miss E. Richards, a contralto, sang "Kathleen Mavourneen," and "Ronald, my darling," and was much appreciated. The whistling solos of Mr. G. Chandler were splendid. Miss Florence Collingbourne, of course, was very popular, her prettiest song being "The honeysuckle and the bee," and also the ever popular "Ma curly headed baby." Miss Sybil Carlisle delighted everybody with "Sally in our alley," and, among other songs, "If no one ever marries me." Mr. Shartau sang some comic songs, and everyone roared with laughter at "The three nice nurses." Miss Chandler sang very prettily; Mr. Ray Edridge recited one of the Bab ballads; Mr. Wyatt sang, and Miss Taylor gave "Croon, croon, underneath the Moon." The ward looked very pretty.

PATIENCE AND SAMARITAN.

The concert in this ward was held on Monday, December 30th, at 6 p.m., and was an unqualified success. The ward looked charming with its wealth of decoration and numbers of fairy lights, and the only feature open to criticism was the heat of the atmosphere, which could not be avoided.

Miss Ormond opened the concert with a piano solo from Greig, which was well rendered, and was followed by a song, "I want the moon," by Miss Ethel Marshall. Mr. Laurence Grossmith next sang a comic song, and as an encore gave a short recitation, "She told me so," which was much appreciated. Following this was a mandoline duet by the Misses Kay, "March des Mandolinistes." The playing of these ladies was quite one of the features of the evening and delighted everyone. Miss Ethel Kay sang "The Girl of the Phillipine Islands" in a fascinating style, and Miss Agnes Walter, "Kissing Time." "The Petals of the Plum Tree" was then given by Miss Mabel Kay, and proved very popular. Mr. Vigers showed his voice to advantage in "Take a pair of sparkling eyes," and the first half of the programme was brought to a close by an excellent comic singer, Mr. H. Brodie, who sang "Me gettee outee quick," and an encore "Nothing New."

After the interval the Misses Kay played a medley on the mandolines, and after much applause played again. Miss Ethel Marshall sang Molloy's popular song, "When Jack and I were children," in excellent style. Mr. Grossmith made a great hit with "Very well, then," as did Miss Mabel Kay with the bouquet song from the "Toreador," and as an encore she sang "I love you, ma chérie." Mr. H. B. Cotton appeared next, and his motor-car song with a chorus went down extremely well. Miss Agnes Walker sang "Annie Laurie," and with such good taste that an encore was demanded, and she gave "Love, could I only tell thee." That ever popular tenor song, "I'll sing thee songs of Araby," was well rendered by Mr. Vigers, and following him was Mr. Winckworth, whose 'cello solo met with such applause that he had to play again. Mr. Julier sang "That's his girl" and "A serial story," in a clever way, and Miss Ethel Kay, "Oh!" and "A lesson with the fan." Mr. Brodie delighted everyone with "Bobs has had a lot of tips from me," and as an encore sang "She was fat."

There was a good audience, and the whole of the proceedings went with a good swing that is so essential to success. The National Anthem was sung, and the evening terminated.

JOB CONCERT.

This was held on Tuesday at 5 p.m. As usual the official programme was nearly useless, three of the artistes being unable to come. Mr. Gerald Ticehurst opened with a selection from "Patience." Mr. Morten Cotton amused everybody with his sketches and songs; Miss Maud Danks, although having a bad throat, delighted everybody with her humourous recitations, especially "I dursn't." Mr. Chandler whistled and Mr.

Warner sang. Everybody liked the Chinese songs of Miss Howard in costume; Miss Chandler sang "Daisy with the Dimple," and a coon song. Miss E. Richard's fine contralto was well heard in "Ronald, my darling." The whistling of Mr. Capper was much appreciated. Miss Lilian Spencer sang "Spring has come." The musical sketch of Mr. Stephen was very good. Mrs. Preston gave two pretty songs, and Mr. Eric Carr sang "A Merry Monk." Mr. Ray Edridge recited, and Mr. Stephens finished the programme with a humorous song. Although there were 600 fairy lights hung up in the ward only one fell down.

ASTLEY COOPER CONCERT.

The concert in Astley Cooper was the last of the series of ward concerts, and formed a fitting ending to such a musical week. The ward was crowded, and the decorations looked excellent, despite the uncertainties of the electric light. The programme was a long one and occupied two and a half hours, but was interesting to the last. Mr. Capper gave two whistling solos which were highly appreciated. The Misses Bush sang "Who is Sylvia," and "The Gondolier," in excellent style. Miss Howard as the "The Chinee Dolly" sang and acted the part very prettily. A violin solo by Miss Mooney was encored. Mr. Woodward finished the first part; his representation of Mrs. Patrick Campbell was especially clever. A vocal quartette, which was very musically sung, opened the second part. Miss Daniell gave "Love the Pedlar." Mr. Beck recited "The house that Jack built." These, and many other items too numerous to mention here, were encored. The concert ended in the proper fashion with "Auld Lang Syne," and "God save the King."

OUT-PATIENT TEA.

It is now five years since Mr. T. W. Landon, in face of certain pessimistic prophecies, successfully carried through the first tea. Nothing really prosperous remains at rest, and certainly this institution from the commencement has flourished like the proverbial "Green Bay Tree," for whilst in 1898, 490 children left the hospital laden inside and out with good cheer, this year 620 sat down to tea, and as we have elsewhere mentioned at the end this number had increased to over 640.

In view of the medical ward concert on the following Friday, the decorations were carried out on a more elaborate scale than is usual—the loftiness of the halls gave full effect to the gaily-coloured lanterns hung from light festoons of holly and ivy.

When the gates opened at two o'clock it was to let in an excited, heaving crowd of eager children, and very quickly tea was being tackled in a most business-like manner—familiarity seemed to have bred contempt for jam—those unacquainted with the "Daily Bread" of the Borough will be surprised that Bread and *Butter* was one of the most favoured dishes.

Before all the tables could be cleared away the Niggers appeared on the scene ahead of their official time (had the rumour of refreshments reached them?); they met with a right royal welcome of yells, shouts and oranges.

After the niggers had marched round the halls and gone on their merry, noisy way, the children were delighted by two cinemotographic displays—one suited to the girls, and the other more to the taste of the boys, which was terribly bloodthirsty, the murder of a missionary was a tit-bit they received with deafening applause—nor was their patriotism less emphatic whenever any British soldiers were shown.

At 5.30, the distribution of toys from the trees took place—dolls, drums and soldiers' hats were in greatest demand. As the children passed out through the lobby they were given a parcel containing tea, bread, sweets, etc. The whole entertainment went off with a splendid "go," and the demonstration of the children clearly indicated their enjoyment and appreciation of all that has been done to give them a jolly Christmas.

So many friends helped that it would be impossible to thank all individually, but especial thanks are due to Mr. Lafone, who sent 100 lbs. of tea; Messrs. Southwell & Co., for their gift of 500 boxes of sweets, and to Mr. Hambro for Christmas trees.

Theatricals.

A BIG SUCCESS.

AMATEUR theatricals, as such, are usually to be avoided if possible, for it is a fact that by no other set of associations has the word "amateur" been so debased. When, therefore, it happens that a really meritorious and artistic production is the result of amateur effort, it becomes a bounden duty to give full prominence to it as a glorious exception to the rule. The residents of Guy's Hospital, after a singularly busy and successful social season, added a fitting climax to their run of triumph by the entertainments on Boxing Night and the night after. It is impossible to speak of those evenings in anything but praise. Minor, or perhaps trivial points, might be criticised but these represent such an inconsiderable part of the whole that the meed of praise must fain swamp the tiny voice of reproach. It is always easy, in a hospital journal, to praise the doings of the individual members; moreover, it is sometimes expected. The GAZETTE, however, has always maintained to the best of its power, the right and spirit of free criticism and it must therefore be understood that the following account in no way takes into consideration the fact that the responsible persons were Guy's men.

The programme of the entertainment was the same on each night—a short concert, a short play, and a somewhat longer farce. The concert consisted of but five items; an overture by the orchestra, two songs, a violin and a 'cello solo. Here, perhaps, we may take the opportunity of thanking the ladies and gentlemen who constituted the orchestra and who contributed no little to the success of the evening. Dr. Eason is to be congratulated on the undoubted success of his efforts. Mr. Winckworth's 'cello solo was admirable, both in

technique and execution, but neither Miss Alcock, Miss Daniell nor Mr. Wyatt was heard to the best advantage on the first night. They all seemed to be a little nervous, probably owing to the unaccustomed effect of the footlights, for on the second night when this source of annoyance was removed, they returned to their old excellence.

Following the concert, with the audience in a condition of mental pleasure, came the production of "In Honour Bound," by Sydney Grundy. It was a bold experiment on the part of the managers to produce a play of this nature. Very little deviation from a standard of great excellence would suffice to make the whole thing a colossal failure. It is, then, the greatest compliment that we can pay the artistes when we say that the production was worthy of any theatre and any audience. The theme is that now made familiar to all in the so-called problem plays. Written, however, before it became customary to enunciate the details with geometrical precision, the play gains much by its inherent delicacy of expression, but at the same time proportionately increases the task of the actors.

Mr. Woodward gave a most thoughtful rendering of the part of Sir George Carlyon, the middle-aged barrister, and in action and dictation was truly admirable. Mr. Woodward has a reputation apart from amateur theatricals, but his performance in this play could only enhance it. Mr. Wacher we know of old, but we must frankly admit that he exceeded our expectations. He was perfectly natural and perfectly in earnest, and interpreted the character of Philip Graham in a manner that could hardly be improved. Miss Adelaide Astor and Miss Beryl Hendbury are both well known in the theatrical world, and with the parts of Lady Carlyon and Rose Dalrymple in such hands the chief difficulty that the amateur stage manager meets with was obviated. Quiet, graceful and sympathetic, these ladies admirably interpreted their parts and completed what was a most artistic and pleasing performance.

The farce, which came last on the programme of the evening, was the well-known one-scene "To Paris and Back for £5." The original book had been written up by Mr. Wacher and Mr. Woodward, and several local allusions added. Although in the hands of, for the most part, absolute novices in stage craft, an extremely creditable and amusing show was produced. Messrs. Wacher and Woodward, of course, played the principal parts and threw a vast amount of humour into the piece. It was remarkable with what facility Mr. Woodward changed into the stammering, irresponsible Snozzle from the previous serious character of Sir George Carlyon. Mr. Wacher was equally happy in his conception of Charles Markam, the hot-headed hero. Naturally, before a Guy's audience some illusion to *plat du jour* was inevitable, and "wheezes" which appealed more particularly to the Nursing Staff were hugely appreciated. Mr. Cross was very happy as the comic waiter and gagged to his heart's content. His make-up, his clever patter and quaint fooleries earned him a ripple of laughter whenever he appeared on the stage. Mr. Bruce gave an effective rendering of the part of Pounce, the detective, and Mr. Butler looked the typical S. E. R. porter. Mr. Grey doubled the parts of paper boy and telegraph clerk on very short notice with success, and Mr. Gibson, in his best gin-and-fog voice was capital as the station superintendent. The other characters were all successfully portrayed, especially the two female parts. Mr. Camps looked a very pretty nurse, a fact which was at once appreciated by the gentler sex in the audience. Mr. Forsyth, as a coy maiden, was very funny and entered into the love-making business with Mr. Wacher with commendable precision, possibly the result of long practice. Mr. Curtis, as the justifiably irrate passenger, was also very well received. On the whole, it was a very good performance, and one which was heartily enjoyed by full houses each night.

Thanks are due to Mr. Barnes, the resident engineer, for the stage and electrical effects which he kindly supplied. Appended is the full programme :—

CONCERT.

Overture, The Orchestra ; 'Cello Solo, "Rêverie de Soir," H. C. Winckworth ; Song, "So fare thee well," H. D. Wyatt; Violin Solo, Two dances from Nell Gwyn, Miss Alcock; Song, "The Shepherd's Cradle Song," Miss Daniell.

"IN HONOUR BOUND."

A Play in One Act.—By SYDNEY GRUNDY.

Sir Geo. Carlyon, K.C., M.P.	H. M. Woodward.
Philip Graham	H. Wacher.
Rose Dalrymple	Miss Beryl Hendbury.
Lady Carlyon	Miss Adelaide Astor.

Scene: SIR GEORGE CARLYON'S STUDY.

"TO PARIS AND BACK FOR £5."

A Farce in One Act.—By MADDISON MORTON.

With additions by "The Bird of Prey."

Mr. Samuel Snozzle	H. M. Woodward.
Mr. Spriggens	H. S. French.
Mr. Charles Markham	H. Wacher.
Lieutenant Spike, R.M.	H. McD. Parrott.
Pounce (*a Detective Officer*)	H. W. Bruce.
Joseph (*a Waiter*)	F. G. Cross.
Superintendent	F. G. Gibson.
Telegraphic Clerk	A. C. H. Gray.
1st Medico	T. J. Wright.
2nd Medico	C. H. Glenn.
3rd Medico	A. Wylie.
Porter	J. A. Butler.
Irate Passenger	F. Curtis.
Paper Boy	A. C. H. Gray.
A Guy's Nurse	P. W. L. Camps.
Miss Fanny Spriggins	D. Forsyth.

Scene: LONDON BRIDGE RAILWAY STATION.

The Orchestra, under the direction of Dr. Eason, consisted of Mrs. Bartholomew, Miss Adamson, Messrs. Bartholomew, Tomkins, Winckworth and Larkin.

S.

Passim.

"But is old, good old Christmas, gone? Nothing but the hair of his good, grey old head and beard left? Well, I will have that, seeing I cannot have more of him."

DRAMATIC critics, writing of the Drury Lane pantomime, are accustomed to extol the performance of each succeeding year as outdoing all previous ones in splendour and brilliance. It's wit is always brighter, its dresses more costly, its transformation scene more dazzling than before. Whilst eschewing these ecstasies, which always have a false flavour about them, suggestive of last year's dish warmed up again, the fact remains that the festivities of the past week were carried through with, if not more, certainly with no less, vigour and enjoyment than in former years. The niggers went their customary round, meeting with their customary boisterous reception from the throats (and hands) of the children in Out-Patients. Concerts were as numerous, and more crowded than ever; and a Christmas which saw such a revelation of latent theatrical and histrionic powers must ever be marked with a white stone. The decorations were lighter in character, but none the less effective; for, though Lamb in his Essays has proved the old adage, *Enough is as good as a feast*, to be a popular fallacy—a "vile, cold, scrag-of-mutton sophism"—the dainty appearance of the wards this Christmas, now heavy festoons are things of the past, went far towards refuting his whimsical logic.

INNOVATION is the order of the day, and not the least successful was the united Medical Ward Concert given in Out-Patients. Hearty thanks are due to those ladies and gentlemen, who, in spite of their many professional engagements, made time to come down and entertain the patients. A glance at the well-known names on the programme is enough to show what an artistic treat was generously given. Nor was the popular element forgotten, as the hearty laughter amply testified. Credit is due to the O.-P. Tea Committee for the decorations, which were more elaborate than usual, and the Sisters are to be congratulated on the striking transformation wrought in the Medical Hall. The refreshment table with its red and white flowers and trails of smilax would have gained a prize for table-decoration anywhere, whilst the numerous little tables and the gaily-tinted lanterns suggested nothing less than Earl's Court.

THE many subterfuges to gain admittance to the Out-Patients' Tea, ranging from "Please admit Two Boys," scrawled on the back of a ticket in a round, childish hand, to the scaling of the Maze Pond railings, speak worlds for the popularity of this treat with the Borough children. Most things on this earth have a limit, and the O.-P. halls reached theirs this year when 620 children sat down to tea. By some mysterious process, this number, at the end of the afternoon had swelled to over 640, though whether this strange increase was the result of Mr. Riggs' excellent fare, or whether some bold spirits contrived to pass the official Cerberus, pleading convenient cuts, etc., will never be known.

IT has been well said that one may live with a man for years and yet never probe the depths of his character. A striking demonstration of this was the theatrical entertainment given by the Residents on Boxing-night and the night after. Sober minded men, whose thoughts had ever been on things professional, suddenly revealed new features of low comedy and anticked with the best; solemn students became riotous demons, blushing maidens, or demure nurses, as the fit lasted, and all for the excellent cause of mirth. That the result amply justified the means was sufficiently obvious to anyone who heard the outburst of applause as each hit was duly digested by the audience. The only thing that gives us apprehension is that this performance may serve as a precedent for later attempts when the material may be lacking. Unless the same standard can be maintained there had better be no repetition. And this was excellent.

THE Niggers, although not boasting the wealth of comic element that was present in the palmy days of the "Disguysed," were quite good this year, and exhibited a new feature, viz., punctuality. The costumes were as gorgeous as ever, and the effectual disguise of blackened faces seemed to put life into many a poor fainting heart, for many of the turns on the day were a decided improvement on the rehearsals. The show went much better for the orderly way in which performers were arranged, instead of finding a place on the nearest window ledge or bed. The choruses were quite strong, even up to the end of the tour; in fact, all that was possible to make the Niggers worthy of the occasion was thoroughly done.

THE various firms of piano makers, as on many former years, have supplied each ward with a piano, some of the instruments this year being exceptionally fine, and our best thanks are due to the makers for their kindness.

THERE was a large going-off dinner on Christmas-night, as all the Niggers were entertained by the Residents. Mr. French announced, amidst cheers, that after very close voting Mr. Gibson had been elected President, and Mr. Parrott, Vice-President of the Residents. The customary toasts to the off-going members of the board were responded to with even greater enthusiasm than usual, and the incoming Residents were welcomed heartily.

THE new appointment list is now quite a thing of the past. Messrs. Collins and Ticehurst succeed Messrs. Cross and Curtis as house-surgeons, and on the Medical side Messrs. Butler and French give place to Messrs. Clarke and Hammond. In the Front Surgery, Messrs. Gray and Pearson are the new assistant house-surgeons, whilst Messrs. Dobson and Greenfield become assistant house-physicians. To all of these gentlemen we offer our heartiest congratulations.

MR. J. A. GLOVER, we are delighted to learn, has been appointed house-surgeon to Mr. Henry Morris at the Middlesex Hospital.

THE Old Year went out and the New One came in just as it has done before in the memory of most of us. The statue of our Founder was decorated, the President of the Residents beat time with flaming torch, and the large ring of men danced wildly round the front quadrangle in the glare of a bonfire, and did their utmost in singing "Auld Lang Syne," with wet feet and muddy clothes, much to the delight of all the onlookers from the many windows, steps and balconies, and the crowd in St. Thomas's Street. The President and others of the Residents were carried shoulder high, or lower according to weight, and custom was satisfied, as were many of the participants in our oldtime festivity.

THE morning newspapers were eagerly scanned by many of us in search for a list of New Year's honours, trusting that some of our worthies might be rewarded, but in vain. However, there is a good time coming, we hope that the day is only deferred awhile.

THE following letter has been handed to us for publication :—

23, Queen's Gardens,
Brownhill Road,
Catford, S.E.,
December 19th, 1901.

DEAR MR. WILLIAMS,

I was very pleased to receive from you on Tuesday last a service of plate, and an address from my fellow-workers and friends at Guy's. Will you convey to them all how much I appreciate this gift, and more especially the kind manner in which they have spoken of me? The twenty-seven years I have spent at Guy's have been on the whole the happiest in my life. From all I have received the greatest consideration. It has always been a pleasure to work at Guy's, for to me it appeared that every one was animated by the desire to make Guy's excel. I am now out of the fight, but I am certain that Guy's, famous in the past, will still be more famous in the future.

I remain,
Yours very truly,
H. COLLIER.

WE would remind our readers that the subscription of twelve shillings and sixpence to the Clubs' Union for the GAZETTE and Reports fell due on the 1st instant, and should be paid as

soon as possible to Mr. S. H. Croucher, at the Medical School Office. Subscribers to the GAZETTE only should send their subscription—seven shillings and sixpence—to Mr. C. H. Wells, Guy's Hospital.

AN index and title-page for the volume just completed has been prepared, and may be obtained from the librarian. Subscribers can now have their sets of the GAZETTE bound for one shilling and sixpence a volume by leaving them with the librarian. The binding is in two shades of blue cloth—navy blue or a lighter tint—with the arms of the Hospital in gold.

WE must congratulate Mr. Philip Turner on passing the M.S. Lond.

Pass List.

University of Cambridge, Michaelmas Term, 1901.

EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

SECOND EXAMINATION, PART II.—E. C. Hughes.

THIRD EXAMINATION, PART I.—Messrs. J. A. Andrews, E. Bigg, H. Davies-Colley, F. B. Manser, F. H. Parker, F. Richmond, J. A. Wood.

PART II.—Messrs. E. I. Claxton, J. S. S. Perkins, E. G. Wales.

University of Oxford, December, 1901.

EXAMINATION FOR THE DEGREE OF DOCTOR IN MEDICINE.

Arthur A. H. Partridge.

University of London.

M.D.—Messrs. J. T. Dunston, H. L. Eason, W. N. East, J. Moore, W. H. M. Telling (Gold Medal).

M.S.—P. Turner.

Papers by Guy's Men.

The Purvis Oration on the Practice of Medicine and Original Research. By J. F. Goodhart, M.D., LL.D. Aberd., F.R.C.P. Lond.—*Lancet*, 21st December.

A Case Illustrating the Effects of Pressure on Early Syphilitic Warty Growths. By Arthur Shillitoe, M.B. Cantab., F.R.C.S. Eng.—*Ibid.*

In Lighter Vein.

THE THEATRICALS.

I.—*A Criticism of the Actors by one of the Audience.*

The first piece, "In Honour Bound," was of a decidedly morbid character, and very bad for the nerves of the nurses. In it Mr. Wacher gave a delightful imitation of a tailor's dummy at Hope Brothers, while Mr. Woodward, as Sir George Carlyon, was in turn George Alexander, Wyndham and Beerbohm Tree. Mr. Wacher reached the sublime when, reading a supposed letter (by mistake a piece of blank paper), he read it wrong, and had to start again. The voice of Mr. Gibson, the prompter, was beautifully heard all over the room.

The next item was a knockabout show in one act. This was funny without being vulgar, all swear words, etc., having been carefully eliminated by the sanitary inspector. Mr. Cross took the part of a waiter, and we have only one thing to say, and that is, "Stick to it, my boy." Mr. Parrott, as a very irate naval officer, nearly blew the scenery off the stage every time he spoke. Dr. Bruce, as a detective, looked hungry. The South-Eastern Railway kindly lent us two of their officials—a superintendent and a porter—for the occasion. We hear that Mr. Camps' representation of a Guy's nurse has caused wide-spread envy among the nursing staff. That Mr. Forsyth, as Fanny Spriggens, was perfect as a ravishing and statuesque beauty is proved by the fact that the police had to clear away a large crowd, members of the Staff and their friends, from the stage-door after the show.

II.—*A Criticism of the Audience by one of the Actors.*

The audience on both nights behaved in a most orderly fashion, and the large force of police held in readiness were quite unnecessary. On the first night the Matron sat in the front row and led the applause. Well to the fore also was the President of the Royal Agricultural Society. [Ed. You mean College of Surgeons.] Dr. Pitt was an interested spectator, and was

seen to smile on one occasion. [Ed. This has been since contradicted.] The ward maids, in great force, kept up a sympathetic giggle throughout. Mr. Hodgson, disguised as a dramatic critic, was seen taking profuse notes on his shirt front. Charlie and Rosie were there, the latter keeping a sharp look-out on the stage furniture.

The second night was very crowded and enthusiastic. One member of the audience was repeatedly heard to bless the actors individually and collectively. It is reported that Mr. Forbes Robertson was present, but perhaps it was someone else. Lastly, at the far end of the room the beaming countenance of Mr. T. P. Thomas shone out like some beacon fire, urging us on to further efforts.

THE BIRD OF PREY.

A Consideration of the Relationship between Superior Protrusion and Mouth-Breathing.

A paper read before the Dental Society on October 11th, 1901, by Mr. H. C. Visick.

MR. PRESIDENT AND GENTLEMEN,—With the growth of civilisation, irregularities in the form of the dental arch have become more and more common, and to-day a considerable item in dental practice is the treatment of these abnormalities, and in this, and possibly preventive treatment, it is of the greatest importance that we have a clear understanding as to their cause.

Perhaps no irregularity has been the subject of so much discussion as that irregularity known as superior protrusion, and some of the theories which have been put forward as to its cause are distinctly original.

For instance, one theorist (Dr. Sims Wallace) is persuaded that the cause of superior protrusion is the atrophy of the tongue due to the delicate diet which is taken nowadays, and he suggests that children should be put upon a hard diet, which would compel them to use their tongues vigorously and thus develop the muscles of that organ. Again, another (Mr. Marcus Davis) says that the English language is at fault in that it has so many words in which the letters "th" occur, such as this, that, these, and that the pressure of the tip of the tongue against the upper incisors in their pronunciation causes the upper teeth to project.

But there are cases of superior protrusion associated with the habit of breathing through the mouth, and it is to these cases that I especially want to direct your attention this evening.

If anyone will take the trouble to examine the many cases of superior protrusion which are continually to be seen in the conservation room, he will find that in a really astonishing number of cases the patients are mouth-breathers—and he will soon become convinced that there is some definite relationship between them.

The first point to come up for consideration is,—Which is cause and which effect?

But before we go into this question it may be well to remind you that until recently mouth-breathing was generally thought to be the result of chronic nasal obstruction in the shape of hypertrophied lymphoid tissue called "adenoids" situated at the posterior nares; but Mr. Lane has proved that the habit of mouth-breathing is acquired in the first instance by an ordinary cold in the nose, and that the failure on the part of the child to clear away the mucous secretions results in the infection of the mucous membrane in the nose, and finally the enlargement of the lymphatic glands in the pharynx. Now, in a paper read before the Odontological Society last year, Mr. Constant described cases of superior protrusion associated with mouth-breathing in which he found no pharyngeal obstruction, and so he concluded that the mouth-breathing must be caused by the protruding anterior teeth keeping the lips apart, but as we have just seen "adenoids" are not necessarily present with mouth-breathing.

Then again, we know that the age at which mouth-breathing usually commences is under six years, at which time only the temporary teeth are erupted, and it is very rare indeed to find the upper deciduous incisors projecting at all, and then not sufficiently to keep the lips apart.

That mouth-breathing is, in some few instances, caused by the dental irregularity seems quite possible, for it is easy to understand that, if for some cause, such as thumbsucking, the upper incisors are made to project to such an extent as to prevent the lips from meeting easily, the child might become a mouth-breather, but these cases will be far from showing the typical features as the mouth-breathing will not have commenced till the eighth year, and probably later. (Case No. 1.)

But I think we may safely say that *usually* the superior protrusion, which makes its first appearance on the eruption of the permanent teeth, is caused in some way by the mouth-breathing.

Before we proceed to discuss the manner in which the mouth-breathing produces such extraordinary effects on the superior maxilla, let me describe to you a typical case. The teeth are arranged in that manner known as saddle-shaped, the two sides being abnormally approximated but especially so in the bicuspid region, the teeth are usually somewhat crowded and the incisors project forwards, being often only partially covered by the lip, and, last but not least, the vault of the palate is extremely high and narrow.

If we can say what it is that causes the high palate, we shall at the same time be able to say what it is that produces the general narrowing of the dental arch, for it

stands to reason that, if the sides of the arch of the palate are pressed inwards the roof must be pushed up, or rather that if the roof does not descend the sides cannot spread normally.

What is it, then, that causes the high vaulted palate and at the same time the narrowness of the dental arch?

Several theories have been put forward to answer this question. One (Mr. Baldwin's), that it is the impact of the column of inspired air against the palate which produces the abnormal vaulting, seems almost too absurd to call for comment; but so many men lean towards this view that a word or two is necessary. In mouth-breathers the respiratory capacity is always very small, the air which is only just sufficient to keep things going being drawn in almost entirely by the action of the diaphragm. The impact (if any) of this current of air, passing through a large cavity like the mouth, must be considerably less than that caused by the current of air which normally rushes through the nose. If this vaulting of the palate, a comparatively thick bone, is so caused, we should expect to get extraordinary results in the nose—but we don't. Many authorities hold that atmospheric pressure is the cause of the high palate, among them Mr. Mayo Collier.

He has shown by experiment that, when one nostril is blocked there is a pressure of half a pound to the square inch on the bones forming the nasal fossa of that side, due to the rarefaction of the air within, caused by the expansion of the lungs. He also quotes Ziem, who "blocked one nostril of a young animal for a long time, and the whole of that side of the face was squeezed in from all parts by the unequal atmospheric pressure, due to the rarefaction of the air from within the obstructed nasal fossa, which prevented the head from growing."

From these experiments he concludes that the contracted and high arch is due to atmospheric pressure. These experiments, although very interesting in their way, have no bearing on the subject of mouth-breathing for several reasons. In the first place the artificial obstruction was only unilateral, and the animal went on forcibly breathing through the other nostril, thus creating an abnormal amount of difference between the pressure inside and out, whereas in the ordinary pathological case the obstruction is bilateral, and in mouth-breathing so bad that the patient is compelled to open his mouth and obtain through it the necessary air, thus putting an end to practically all the air currents in the nose.

Again, the artificial obstruction was at the anterior nares, and so the partial vacuum took place within the nasal fossa; but in the natural case the obstruction is usually situated at the posterior nares, and so the partial vacuum does not take place place further forwards than that obstruction.

The fact that in mouth-breathing practically no air passes through the nose, conclusively proves (to my mind) that the non-development of that passage is due, not to the presence of an abnormal factor, but to the absence of a normal one. Whether that absent factor is the mechanical pressure exerted by the normal respiratory air alone, or whether it is a combination of that, and a physiological factor dependent on the use of the nasal fossæ for their normal function, is not certain.

Mr. Lane's views on the subject seem to me to be by far the most natural and convincing in every respect, and as he looks at it from the point of view of a general surgeon, he is able to judge of the real cause in this instance better than we, who are so prone to consider these cases from a purely dental point of view, which is inclined to be narrow.

I cannot do better than quote to you a few extracts from the remarks which Mr. Lane read before the Odontological Society in February, 1901, at the discussion of Mr. Constant's paper on the "Etiology of Superior Protrusion" (p. 104, Transactions of the Odontological Society, February, 1901).

"We must remember that the functions of the bones of the face are three in number :—

1. To surround the passage by which air alone is transmitted to the lungs.

2. To sustain the strain exerted by the muscles of mastication, and to transmit and diffuse the resistanc offered by the crushed food in the forcible approximation of the teeth during its attrition.

3. To surround and protect the eyes."

Experiments are made by nature on all sides, showing the influence which the exercise of the several function exert upon the skeleton, all capable of accurate measurement and definition. If an eye be removed early in life, the degree of development of the orbital space which contained it, and of the soft parts which surrounded it, is less than that which exists on the opposite side. Such imperfect development of the skeleton as arises in consequence of the absence of the pressure exerted by the globe of the eye is very limited.

If the permanent teeth are removed early in life, the alveoli waste and the bones along which force is distributed, either as pressure or strain, become thinner and thinner. If in the growing child, however, the teeth are prevented from performing their normal functions, as for instance, by ankylosis of one or both temporo-maxillary articulations, we find that the lower jaw develops much less rapidly than does the upper, showing two things :—

1. That besides the presence of the teeth there is an additional factor controlling the development of the upper jaw that does not influence the lower to anything like the same extent when movement of these bones upon one another does not exist.

2. That in a normal skeleton the lower jaw is dependent for its perfect development upon that of the upper.

The removal of the function of the nasal cavities in the growing child produces an influence on the development of the bones of the face which is most marked, and varies directly with the completeness of the loss of function, and inversely with the age of the child. The factor upon which the bones which surround the nasal cavities

depend for their development, is the pressure exerted upon the interior of the spaces by the air as it passes through them.

It is this pressure that increases the breadth of the nasal space and determines the degree of development of the cavities in the superior maxilla and elsewhere, which communicate directly with it. In consequence of this lateral development of the nasal spaces, the anterior surface of the upper jaw is rendered prominent anteriorly, and the malar bone antero-laterally. For the same reason the alveolar arch is widened. Pressure is exerted in a downward direction, depressing the arch of bone which separates the mouth and nasal cavities, and tending also to increase the breadth of the alveolar arch of the upper jaw.

Fig. 6, representing a vertical transverse section through a normal upper jaw, shows at a glance the directions in which force, exerted at right angles to the surfaces of the nasal space, tends to produce change in surrounding structures. Again, this force exerts a pressure also in a forward direction, tending to project the nasal bones and septum anteriorly. The atmospheric pressure upon the interior of the nasal cavities tends to increase the length of the alveolar arch of the upper jaw, providing ample room for the teeth, to enlarge the interval between the alveolar margins laterally, to make the anterior portion of the arch more rounded and convex forwards, and to diminish the height of the palate. If the lower jaw is capable of moving normally upon the upper this atmospheric pressure exerts an indirect influence on its development, which, as I have shown, can be readily measured in cases in which such movement is in obeyance."

Mr. Lane then goes on to consider the general condition of the subjects in which such loss of function is found, and says that the most marked feature in their condition consists in a deficient performance of the respiratory function, and by their deficient oxygenation the resisting capacity of the tissues to the entry of organisms is correspondingly diminished. In consequence the child is affected with a sequence of colds.

"The infection of the mucous membrane of the naso-pharynx produces an enlargement of the glandular tissue in the naso-pharynx (called the pharyngeal tonsils), of the faucial lymphatic tissue, and of the lymphatic glands in the neck. The result of all this is that the nasal cavities no longer transmit air, or only a small proportion of the normal amount, and the bones of the face are for the time being deprived more or less completely of the mechanical factor on the presence of which they are dependent for their complete development. In consequence the nasal cavities are narrow, and the spaces that communicate with them laterally are small, and the bones surrounding them have not their normal prominence. Again, the length of the alveolar arch is diminished so that the teeth are crowded, the sides of the arch are abnormally close and the palate is high, the front of the arch is displaced forwards, so that the upper incisors project much beyond the lower. This model represents a vertical transverse section through such a palate and alveolus, and in contrasting it with Fig. 6 it is seen at once that the differences which exist are clearly consequent on the imperfect development of the nasal cavities."

From these extracts you will see that the high palate and general approximation of the alveolar ridges are fully accounted for, but I think we have a further cause for the especial instanding of the bicuspids.

We know what a very slight cause, such as a piece of retained temporary tooth, will alter the direction of an erupting tooth, when it has practically no socket; it is easy to understand, therefore, when the teeth erupt into this small, narrow arch, where they cannot arrange themselves in a row but must overlay somewhere, that only the slightest influence is needed to determine their position either inside or outside the arch.

This determining influence we have in the slight pressure which is put upon the bicuspids by the cheek at the angle of the mouth and the absence of the normal pressure of the tongue on the inside.

The superior protrusion caused by mouth-breathing in a typical case is not so excessive as one might expect, because the canines coming down into the already crowded arch, instead of forcing the incisors further forward, simply slide the laterals in behind the centrals.

Cases Nos. 2 and 3 show this condition very well. No. 2 has been a mouth-breather since birth, and No. 3 as long as her mother could remember, but you will see by the photos that neither of them have anything like the superior protrusion that Nos. 1 and 4 have, who, as far as can be ascertained, did not start mouth-breathing till after the eruption of the permanent teeth.

Here are two vertical sections through the palates of Nos. 2 and 3.

Mention may be made here of the circumstance that in the normal condition of things, the tongue is applied to the hard palate, and according to Donders "At the back part of the dorsum of the tongue it is separated from the palate by a small space, and there is a negative pressure in this space equal to 2 to 4 m.m. of mercury, caused by the weight of the jaw, which is maintained in position, not by muscular effort, but by the pressure of the atmosphere." If this is so, it seems possible that the negative pressure, slight though it may be, might have some influence on the descent of the palate; in mouth-breathing this influence would of course be lost. In conclusion, let me quote to you, from Mr. Lane's remarks, a passage on treatment:—

"That the development of the bones of the face can be materially influenced by the restoration of the influence of the mechanical factor, I have proved without question to my complete satisfaction, and the amount of alteration obtainable varies with the thoroughness of the restoration, with the age of the individual, and with the amount of imperfection, whether acquired or hereditary. On this account the return to the normal type is rarely complete, and in the case of the alveolar arches, and the arrangement of the teeth, the removal of some, and pressure

exerted by mechanical arrangements upon others, are very important additional aids."

As these cases are not usually brought up for treatment till considerable deformity has resulted, I fancy it will be very much "mechanical arrangements."

Thank you, gentlemen, for the kind attention you have given to what is, I fear, a very lame attempt at a paper.

Types.

No. I.—The Amorist.

"I am, in plain terms, what you call a Rover, or a general Lover . . . all from the fine Lady down to the dextrous Molly, who waits with the kettle, have made scars or wounds in my heart."—Steele and Addison.

He was a good example of what our dramatic critics love to call the clean-limbed youth of England; at one time he was rigidly clean-shaven, preferring to let the girls take the hidden possibilities (or impossibilities) of his beard for granted; but recently he has, with much care and thought, produced a little—a very little—moustache, which, in the innocence of his heart, he believes stamps him for a man, whereas it says to all the world, "What a boy am I!" His dress was a carefully-selected combination of serge, silk and shine.

"I say, old chap, come up and have tea with me."

A mixture of conceit and naïveté is always interesting to an onlooker, so I accepted.

"Sit in that chair. Have a pillow? Jolly pillow that! worked for me by Blanche L——, when I was staying with her people last winter. Awfully jolly girl! She and I were awful pals!"

"Do you mean the Blanche L—— who married that South African fellow last June?"

"Yes, why? Do you know her?" (anxiously).

"Well, yes. I was only thinking I should hardly call her a girl; thirty-seven is a bit over the line." His face fell.

"Oh, I don't know about that. Anyhow a chap is always safer with that sort."

"I should have thought you were always safe——" but he was my host, so I added as a saving clause, "since they say there is safety in numbers."

But I need not have troubled. He was already describing a girl I knew; he had met her during the summer at Brighton.

"Awfully smart! Blue eyes and black hair——"

"How very odd!" I said, groping in my pockets. He stared.

"What the deuce do you mean? Why—she was a reg——" He looked black.

"I wonder where I can have put my pipe." His face brightened again at once.

"Have a cigarette" (producing a very ornate case, with his initials done in bright stones).

"Jolly case that! *She* gave it to me."

"No one's likely to steal it." (He looked irritated.) "The initials are so clear." (He smiled.)

The next moment he was rummaging about in a drawer.

"What are you looking for? I have a match."

"I want to show you her photo."

"Don't trouble; I've got one."

"G—got one!!!—why!—where did you buy it?"

"Didn't buy it—unless you count kisses as current coin," (with a faint flush—for even the most cynical of us in our heart of hearts, have a weakness for being thought potential Don Juans.)

He looked so miserable, that I was almost sorry for him. But happening to glance towards the window——

"Oh! I see you are looking at that picture of Lottie ——," he began. In reality, I was watching Harold doing his hair at the opposite window. But he was under full sail, and why should I stop him? He was happy again; the fire was cosy and I was comfortable.

"Why, old chap, you're asleep!"

And so I was.

ONLOOKER.

Presentation.—Mr. M. A. Adams, F.R.C.S. England, was on November 29th presented with his portrait in oils in recognition of his long gratuitous and beneficial services as Surgeon to the Kent County Ophthalmic Hospital. The portrait will be suspended on the Hospital walls.—*Lancet*, 21st December.

Nursing News.

MATRON'S OFFICE.

On December 16th, Nurse Palmer, Head Nurse in the Theatre, was transferred to the Eye wards, and Nurse Coleclough, Head Nurse in the Eye wards, was transferred to the Theatre.

The following Probationers have passed the Examination in Medicine held on Thursday, January 19th, 1901:—Probationers Anderson, Archbold, Atkey, Barker, Bell, Bennett, Boodle, Broome, Campbell, Cantwell, Carter, A. Clarke, Cooper, Cornwell, Coward, Collie, Crampton, Dann, Dickson, Densham, Du Boulay, Edmonds, Essex, Foster, Fox, Gilbert, Gill, Grigor, Gyles, Harris, Harden, Hawes, Hayward, Haslar, Heritage, Horsepool, Jenkins, Kendle, Leonie, Maddison, Manning, McFarlane, McCalmont, Medley, Melia, Millidge, Millard, Morley, Mott, Mortiboys, Nawn, Norman, Parr, Pearse, Pettit, Plant, Powlett, Purse, Riley, Ripley, Scott, Sheldon, Spink, Smith, Spreckley, Stanton, Studdert, A. Topping, E. Topping, Thorpe, Ulliac, Watson, Ward, Webb, Wheatley, Wilkinson, Windemer, Wise, Witchell, L. Wood, Woodward.

On December 26th Nurse Gatward left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff. Probationer M. Davis has been appointed to succeed her as Head Nurse in Lazarus ward.

On Thursday and Friday, December 26th and 27th, the Nursing Staff were invited to a dramatic entertainment given by the Residents in the Court Room. Two very enjoyable evenings were spent, and we are sure everyone will agree with us that great praise and thanks are due to the ladies and gentlemen who took part in the performance.

The Society of Medical Phonographers.

(REPEATED NOTICE.)

This Society will hold its next Annual Shorthand Examination early in May, 1902. Two prizes will be offered, each of the value of £5, one for first-year students and one for students of more than one year's standing. The competition will be open without entrance fee to any Registered Medical Student in the United Kingdom who has not taken a first prize at one of the Society's previous examinations. It will be held simultaneously in London, Edinburgh, Dublin, and at any provincial medical centre in the United Kingdom at which not fewer than three Candidates shall offer themselves.

Intending Candidates should send in their names as early as possible to Dr. P. G. GRIFFITH, Bonhams, Farnborough, Hants, who will furnish them in return with a detailed Prospectus of the Examination.

The *latest date for receiving entries* will be April 15th, 1902.

Appointments.

CIVIL.

DENYER, STANLEY E., C.M.G., M.D., D.P.H. Cantab., has been appointed Assistant Demonstrator in Anatomy in the University of Cambridge.

HIND, WHEELTON, M.D. Lond., F.R.C.S., has been appointed Senior House Surgeon to the North Staffordshire Infirmary and Eye Hospital, Stoke-on-Trent, *vice* W. D. Spanton, F.R.C.S.

NAVAL.

Surgeon R. W. B. HALL, R.N., has been appointed to the *Grasshopper*.

Staff-Surgeon EDWARD J. MORLEY, R.N., has been appointed to the *Magnificent*.

ON December 10th, a bronze medallion portrait of the late Professor Tom Jones, which has been placed in Owen's College Medical School, was unveiled in the presence of a large gathering of friends and students.—*Brit. Med. Jour.*, Dec. 21st, 1901.

Birth.

THOMSON.—On December 15th, at Kirkston, Spa Road, Radipole, Weymouth, the wife of David Thomson, L.R.C.P. Edin., L.R.C.S. Edin., L.F.P.S. Glasg., of a son.

Marriages.

BOWEN-JONES—EVANS.—On December 12th, at St. Catherine's Church, Neath, South Wales, Lloyd Bowen-Jones, M.R.C.S., L.R.C.P. Lond., D.P.H., to Clara, daughter of the late Edward Evans, Esq.

MACCONKEY—DIXON.—On December 31st, at St. James's Church, West Derby, Liverpool, by the Rev. A. W. Robinson, Alfred Theodore MacConkey, M.B., B.C. Cantab., son of the late Rev. Andrew MacConkey, Incumbent of St. James's, West Derby, Liverpool, to Henrietta Mabel, daughter of Alfred Dixon, Esq., late of Marshfield, Seaforth, Liverpool.

VAN SOMEREN—FLETCHER.—On January 2nd, at the Parish Church, Northwood, by the Rev. E. B. Backhouse, Ernest Herbert van Someren, M.R.C.S., L.R.C.P., of Venice, Italy, to Grace Ivy Ethel, daughter of Mr. and Mrs. Horace Fletcher, of Palazzo Saibante, Venice, Italy.

Death.

WATSON.—On December 24th, at Clifton Villa, Rochester, William Watson, M.R.C.S. Eng., L.S.A.

ED.—D. G. G.

Contents.

	PAGE
THE LORD MAYOR'S APPEAL ON BEHALF OF THE HOSPITAL	21–30
TYPES	30
PAPERS BY GUY'S MEN	30
A "SEND-OFF" DINNER	31–32
CHAPEL NEWS	32
CORRESPONDENCE: Masonic Lodge; A Correction	32
APPOINTMENTS	32
PASSIM	33–35
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	35
TYPHOID FEVER: Clinical Lecture by Dr Washbourn ...	36–39
A CASE OF GASTRIC ULCER WITH TETANY AND DIACETURIA. By David Forsyth	40–43
IN LIGHTER VEIN	43–44
NURSING NEWS	44

Calendar of Coming Events.

January, 1902.

Sat. 18.—Messrs. Lucas and Lane's take-in; Drs. W. Strange and B. H. Wedd; Cl., P. N. B. Odgers.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Rosslyn Park, home.
III., U.C.S. Old Boys "A," away.
G.H.A.F.C., I., Beckenham, home.
II., Beckenham 2nd XI., away.

Mon. 20.—1.15 p.m., Clinical lecture by Mr. Higgens.
Wed. 22.—1.30 p.m., Clinical lecture by Mr. Jacobson.
Thur. 23.—Messrs. Golding-Bird and Dunn's take-in; Drs. P. C. V. Bent and L. S. H. Glanville Cl., W. M. Robson.
G.H.C.U., Address by W. Fisher, Esq.
Sat. 25.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Rosslyn Park, home.
II., Beckenham, home.
G.H.A.F.C., I., Weybridge, away.
II., Hampstead 2nd XI., home.
Mon. 27.—1.15 p.m., Clinical lecture by Dr. Perry.
Wed. 29.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.R.F.C., II., St. Bart. II., home.
G.H.A.F.C., I., Casuals, home.
Thur. 30.—G.H.C.U., Address by Rev. Cecil de Cartret.

February.

Sat. 1.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., R.I.E.C., away.
II., Polytechnic, away.
G.H.A.F.C., I., Ewell, away.
II., Central Technical College, home.

Guy's Hospital Gazette.

JANUARY 18, 1902.

The Lord Mayor's Appeal on behalf of the Hospital

FOR A RENOVATION AND BUILDING FUND OF £180,000 AND FOR THE RAISING OF THE INCOME OF THE HOSPITAL TO £60,000 PER ANNUM.

MEETING AT THE MANSION HOUSE.

A LARGELY attended and influential meeting was held at the Mansion House on the 15th instant in support of the appeal. The LORD MAYOR (Sir Joseph Dimsdale, M.P.), who was accompanied by the Lady Mayoress, presided, supported by the sheriffs (Mr. Alderman Bell and Mr. Brooks Marshall) and among those present were:—

The Earl of Leven and Melville, the Countess of Bective, Lord Henry Bentinck, M.P., Lord Revelstoke, Lord Cottesloe, the Hon. Sir Charles W. Fremantle, K.C.B., General Sir R. Harrison, K.C.B., Sir W. Cameron Gull, Hon. Evelyn Hubbard, Sir Samuel Wilks, Bart., F.R.S., Mr. Leopold de Rothschild, The Hon. Alban Gibbs, M.P., Mr. R. K. Causton, M.P., the Chief Rabbi (Dr. Adler), the Archimandrite (Dr. Paraschis), Colonel J. F. Curtis-Hayward, Colonel F. A. Lucas, M.P., Alderman and Sheriff Bell, Mr. Sheriff Marshall, the Prime Warden of the Fishmongers' Company, the Masters of the Grocers', Merchant Taylors', Skinners', Salters', and Haberdashers' Companies, Mr. Robert Barclay, Mr. E. H. Lushington, Mr. F. H. Norman, Mr. W. S. Seton-Karr, Mr. Hugh Colin Smith, Mr. J. Herbert Benyon, Mr. Everard Hambro, Ven. Archdeacon Lawrence, Mr. R. A. Hankey, Mr. A. J. Lawrence, Mr. R. E. Johnston, Mr. Henry Lafone, Mr. Robert Gordon, Mr.

Charles Gassiot, Mr. Frank Debenham, Mr. Thomas A. Mason, Mr. Charles R. G. Hoare, Mr. M. Trevelyan Martin, Mr. Herbert H. Raphael, Mr. A. C. Cole, Mr. John Morris, Rev. Walter Howse, Dr. Pye-Smith, Mr. Thomas Bryant, Dr. Frederick Taylor, Mr. H. G. Howse, Dr. Perry, Dr. Fawcett, Mr. Golding-Bird, Mr. W. Arbuthnot Lane, Dr. Galabin, Dr. Newton Pitt, Mr. Brailey, Mr. Clement Lucas, Mr. Fripp, Dr. Shaw, Dr. Washbourn, Dr. Bryant, Mr. Fagge and Mr. Ormond.

The Treasurer announced the receipt of letters of regret at their inability to be present, and in support of the object of the meeting, from :—

H.R.H. the Duke of Cambridge, Lord Salisbury, Lord Rosebery, Lord Cross, Lord Pembroke, Lord Wemyss, Lord Avebury, Lord Aldenham, Lord Ashcombe, Lord Farquhar, Lord Lawrence, Lord Rothschild, the Bishop of London, the Bishop of Winchester, the Bishop of Rochester, Cardinal Vaughan, the Hon. and Rev. A. V. Lyttleton, the Honourable Lady Gull, Lady Esther Smith, Sir Frederick Wills, Sir C. T. Dyke Acland, Sir Samuel Hoare, Sir David Salamons, Sir George Pilkington, M.P., Colonel Bevington, Mr. J. Pierpont Morgan, Colonel Hanbury Barclay, Mr. Alfred Harmsworth, Chairman of Lloyds, Chairman of the Stock Exchange, and the Mayor of Southwark.

He had also received the following letter from Mr. Balfour, who is a Governor of the Hospital :—

10, DOWNING STREET, S.W.,
January 10th, 1902.

MY DEAR BONSOR,

I very deeply regret my enforced absence from the Mansion House meeting on Wednesday next. The immediate assembling of Parliament, however, renders that date peculiarly inconvenient, and the pressure of other work deprives me of any hope of being present. I particularly desired to take part in your proceedings, for I strongly feel that the occasion is a unique one, and that on the success of your efforts to collect funds depends, in no small measure, the future value of the work which it will be in the power of Guy's Hospital to perform in the service of humanity and of science.

The necessity of a capital expenditure of £180,000 is, I well know, imperative. Without a modern equipment this great Institution cannot effectively carry on its beneficent work ; and when it is remembered that this work has now for nearly two hundred years not only alleviated the sufferings of the poor, but contributed its full share to those marvellous advances in the science of healing and nursing by which the whole community, irrespective of class, so largely benefit, I cannot think that any difficulty should be found in providing the money.

With the earnest hope that London will not suffer the discredit of withholding this needful aid from one of its most admirable institutions,

I beg to remain,
Yours very sincerely,
(Signed) ARTHUR JAMES BALFOUR.

H. COSMO O. BONSOR, Esq.

THE LORD MAYOR : Mr. Cosmo Bonsor, my lords, ladies, and gentlemen,—It has been my privilege on many occasions to plead for charities and benevolent objects, but I have seldom pleaded on behalf of a charity which deserves more thorough, hearty, and generous support than does that noble institution, Guy's Hospital. This hospital, established in 1724 by Thomas Guy, a citizen of London, from its inception held a leading and important position among the charities and benevolent institutions of the metropolis. Little did Thomas Guy think when he founded this hospital that it was destined to develop to its present proportions, or to carry out that immensity of good that it does to-day for the suffering poor and also for the rich and well-to-do ; for, believe me, the rich and well-to-do are quite as much assisted by the labours of our fine medical schools, and the result of the untiring labours of our physicians and surgeons in the wards of our hospitals, as our poorer and less fortunate brethren. The results of the education given in the schools and wards of our hospitals are not confined to the hospitals alone, nor to the great metropolis alone, but rather are at the disposal of the community at large, and so for the benefit not only of this kingdom, but the Empire in general. The expansion of this great hospital has been enormous. Whereas, in 1724, or shortly afterwards, in the time of Thomas Guy, fifty nurses were deemed more than ample to carry out its requirements, we find at the present day two-hundred and thirty nurses barely sufficient. And the work could not be done with the numbers unless the staff and the nurses worked as one together, with no personal ends but with one object, namely, the welfare and the alleviating the suffering of mankind. It is a regrettable fact, that even with this expansion, owing to the want of funds, there are still beds closed, and those beds cannot be re-opened unless the benevolent public give the wherewithal to keep them in active service. This hospital is absolutely essential to the metropolis. It has around it one of the poorest districts in London, and I can hardly believe, in fact I will not believe, that the benevolent public, and those who feel that in their affluence and wealth they are merely trustees of the blessings that God has given them, will for a moment allow such an institution to suffer and its immense opportunities for good and benevolence to be

curtailed. The history of Guy's Hospital, I believe I am right in saying, is unique amongst the hospitals of this metropolis. From 1724 up to 1880 it was an absolutely self-supporting institution. Unfortunately, a very large portion, by far the larger portion, of its income was derived from real property, and the depression of the agricultural interest so militated against the hospital that its income was absolutely knocked down to the extent of nearly fifty per cent. That is really the reason of one of the appeals which come before you to-day. I am going to ask the citizens of London, I am going to ask the people of our country, to come to the assistance of this great and absolutely essential institution. The financial statement is in a nutshell. To carry on efficiently and well, to maintain this hospital worthily as one of the greatest hospitals in London, it is necessary, even with economy and very careful supervision, to have an income of something like £60,000 a year. The only reliable income which the Governors can really place their fingers upon is £35,000 a year. It is perfectly true that there is £11,000 a year, which they hope may be continued, but you must bear in mind that that £11,000 a year is hedged round with conditions and restrictions, and as business men they hardly can look upon this sum as a certain income. I am, therefore, going to ask you not only to do your best to find £25,000 a year, but to interest your friends, and to use your influence with that object in view, and thereby of placing at the disposal of the Governors of Guy's Hospital a sum per annum which will lift from their shoulders that perpetual anxiety and that perpetual doubt as to whether, commencing a new year, they will be able at the end to have the wherewithal to make both ends meet. But there is something beyond this. I need hardly remind you that an institution which has been in existence for the length of time that Guy's Hospital has needs a large amount of fabric work to keep it abreast of the times. Anyone interested in hospitals—and I rejoice to think that this is not the only hospital by one, or two, or three, that I am interested in myself—must know that a hospital which is not thoroughly up to date had better not exist. I am, therefore, pleading not only for an increased income to properly maintain this great establishment, but also for £180,000, with which to meet those necessary calls for capital outlay which are enumerated in the Governors' official statement. I may point out that this £180,000 will not be required absolutely all at once. Therefore, I would ask you to let your friends know and to realise yourselves that, if it is more convenient, donations, spread over three or five years, will be quite acceptable. I can imagine that some may ask, who are not so conversant with the affairs of Guy's Hospital as the Governors and those intimately connected with it, What work is Guy's Hospital doing? I will only remind you that the in-patients accommodated in 1900 numbered no fewer than 7,320, and the returns for 1901 bring up the total to a still larger aggregate, namely, 7,811. But when we look to the Out-patients' Department, we find that as many as 120,849 poor sufferers were relieved by this noble institution in 1900, while the maternity cases attended in their homes in the same year reached 3,413. These figures require no comment from any chairman. I appeal for a charity and a great hospital, which is absolutely essential to this metropolis, and to the welfare, the healthiness of the entire community; and Guy's Hospital, with its magnificent nursing establishment, does not confine its work within the walls of the hospital, but sends its doctors and nurses not only throughout this kingdom, but throughout the Empire. It is a privilege, Mr. Cosmo Bonsor, for me, as the Chief Magistrate of the City of London, to greet you here, together with your friends, who are interested in this great work. Here, in the old Mansion House of the City of London, we find the centre of charity and benevolence. We plead for a grand hospital, established nearly 200 years ago by a fine old citizen of London, and I leave it in your hands, ladies and gentlemen, I leave it in the hands of my fellow-countrymen, who ought to realize, and I know will realize, that if they are blessed with this world's goods, it ought to be not only their pleasure, but their duty to assist and help those poor who cannot help themselves, looking for a far higher reward than any that can be given them this side of the grave.

MR. COSMO BONSOR: You, my Lord Mayor, have been so good as to grant the loan of the Mansion House for the purpose of an appeal in favour of the funds of Guy's Hospital. In thanking you for the speech which you have just delivered, and for the use of this hall, I have on behalf of the Governors to state that a period in the conduct of their trusteeship has arrived when they require the cordial support and the financial assistance of the citizens of London. You, my Lord Mayor, have well reminded this meeting that the hospital was founded by a citizen of London, that it was founded for the purpose of relieving distressed humanity, and I believe that I am right in saying that the principal object which influenced Thomas Guy in his benevolence was that no sick person whose malady might seem incurable should be turned out of the hospital for the purpose of dying. That tradition has been one of many which is connected with our hospital, and will, I anticipate, appeal forcibly to all kind-hearted people. It was, I think, in 1882 or 1883—very soon after I had the honour of becoming a Governor of the hospital—that the question of its finances was seriously taken in hand by the Governors. The question that the Governors at that time had to consider was, whether they were merely trustees for the distribution of the endowments left them by Thomas Guy, which endowments, by reason of fallen rentals, were reduced to a half of their one-time value, or whether they had a further duty to the public, in the locality in which they were placed, of providing, to the best of their means and opportunity, accommodation for the sick poor. I need hardly say that the answer to the question was never in doubt. The Governors in the first place collected among themselves and their personal friends a sum of £12,000 to relieve the embarrassment of the time, and shortly after-

wards they made a public appeal, principally to the bankers and merchants of London, for support. This appeal met with a warm response, and sufficient funds were thus raised to enable the Governors to keep a reduced number of beds open until the year 1895. In the autumn of that year my predecessor, Mr. Lushington, who I am delighted to think is here to-day and still taking an active interest in the welfare of Guy's Hospital, made a further appeal to the public for the purpose of replacing the loss of income which had occurred through the decreased agricultural rental coming to the hospital. The late Mr. Gladstone, who was one of our senior Governors, wrote an eloquent letter, to which we attributed gifts of £30,000; and having started the appeal well on its way, Mr. Lushington resigned his position as treasurer at the same time that Lord Aldenham, whose name is always popular in the City of London, resigned his position as president of the hospital in favour of the Prince of Wales, now His Majesty the King. As president of the hospital, the King signalised his acceptance of the office by personally leading a new movement, having for its purpose the re-endowment of the hospital to the extent of its losses, and the response of the public was exceedingly generous, but insufficient to finally rescue the hospital from its difficulties. His Majesty was afterwards gracious enough to open the new Medical School Buildings which had been built by the Medical Staff out of their own resources, and he expressed a strong wish that the Governors of the hospital should make an effort to re-open all the beds that were closed. On behalf of the Governors, I, as treasurer, undertook that obligation, and all our efforts since 1896, and the extra expenditure that has been undertaken, have been directed to the one end of throwing open the whole of our 650 beds to the service of the sick poor. To open 150 closed beds under modern conditions of medical science and professional nursing, necessarily required a heavy expenditure. In the early days of the hospital's history 50 nurses were considered sufficient for the needs of the patients, messengers being sent out into the neighbourhood to get voluntary assistance when necessary. To-day we have 230 sisters and nurses, and every nurse in charge of a sick patient must be thorougly trained and thoroughly efficient. Then the older wards of the hospital had to be re-modelled, for the sanitary and general arrangements which sufficed 180 years ago could not be contemplated by any medical staff as wholesome at the present day. Again, the washing of the linen necessary to an establishment of this description under modern requirements is very different to what it was even within living memory. I need hardly endeavour to draw the comparison. Moreover, our old laundry was worn out. The expenditure on a Nurses' Home capable of lodging the nurses required for the care of 650 in-patients is of necessity a large one, and the Governors would have hesitated before embarking on such an enterprise had it not been for the generosity of the late Mr. Henry Raphael, who called upon me one cold morning in January, 1898, and after having visited the attics in which our nurses were lodged, and inspected an adjoining site where it was possible to build a Nurses' Home, took me back into my room and gave me a cheque for £20,000 to that object. That donation was the first direct encouragement which the Governors received towards the outlay which is requisite to bring Guy's into an absolutely efficient condition. Since then the Governors have received many encouragements. The Medical and Surgical Staff of the hospital, acting in cordial co-operation with the Governors, have been good enough to subscribe out of their own pockets the large sum of £1,800. Many of the Governors of the Hospital have not only given large subscriptions, but at times when I, as treasurer, with debt staring us in the face, have felt it my duty to say that certain of the works should be stopped, some of them have come forward as individuals to undertake particular improvements. And the poor recipients of the charity have done what they could. In-patients and out-patients, either directly or indirectly, have contributed £500 during the last twelve months, absolutely voluntarily, on leaving the hospital after receiving its benefits. The Press has been most generous. Not only did they publish our present appeal and my letter calling attention to the wants of the hospital, but in many instances the leading journals have sent their representatives to the hospital to ascertain for themselves the justification for the appeal we are making, and have written articles describing our work and calling public attention to our needs. Besides these encouragements, I have received an intimation that many men who are working on the railways in close proximity to the hospital are making a private subscription among themselves for the purpose of assisting us, and through the great kindness of Mr. Beerbohm Tree, a special evening performance will be given at Her Majesty's Theatre in the spring. A good friend of the hospital, the Countess of Bective, who is present with us to-day, is most generously placing her great influence and organising abilities at our disposal in connection with this performance, and we look forward to the occasion being worthy of the cause and of this Coronation year. These are the conditions under which we, as Governors of the hospital, come before the citizens of London. Our requirements are, firstly, a sum of £180,000 to meet the cost of those works to which I have referred and those other works which are fully enumerated in the published statement of our case, and, secondly, for an additional income of not less than £14,000 per annum. We make a direct appeal to the bankers and merchants, to the traders, and also to the City Guilds, to assist a great institution which for so many generations has carried on its work of charity. We ask them to do the same as the Press—to come and see for themselves the work that is being carried on. We should point out to them that in spite of every difficulty, Guy's Hospital is rendering to-day a greater service than at any previous period; that we accommodated during the year just passed 7,811 in-patients—a record number; that in the same year

upwards of 120,000 persons were treated in our Out-patient Department, and that over and above this vast work which goes on from day to day within the walls of Guy's Hospital, our Maternity Charity, which embraces that district on the south side of the Thames containing more poverty and distress than any other portion of London, gives skilled care to nearly 4,000 lying-in cases per annum. Nor is the work only confined to the patients. We pass out into the world every year large numbers of the most highly trained medical men and nurses, who go forth carrying for the benefit of mankind at large the art of healing which they have learned in Guy's Hospital. I will not carry my case any further. I believe that I have said enough for the citizens of London to recognise that it ought to be impossible to allow a hospital such as Guy's, standing within a stone's throw of the greatest, richest and best governed city in the world, a hospital, too, with such noble traditions, to suffer neglect or to continue in a state of financial embarrassment.

MR. LEOPOLD DE ROTHSCHILD moved the following resolution :—

"That this meeting having heard the speech of the Rt. Hon. the Lord Mayor, and the statement of the Treasurer showing the present urgent financial needs of Guy's Hospital, earnestly commends the same to the support of the citizens of London and to the benevolent public throughout the country in the hope that sufficient assistance may be immediately rendered to enable the Governors to maintain the work of that great institution in a state of completeness and efficiency."

It is a great pleasure and a great honour to me, proceeded Mr. Rothschild, to have the honour of proposing this resolution, which ought to have been moved by my brother, Lord Rothschild, who is unavoidably absent, and who is Treasurer to His Majesty's Hospital Fund. That fund, inaugurated by the King and supported by His Majesty, shows that Guy's Hospital is worthy of support, this institution receiving from the fund, year by year, a substantial allowance. It is a happy augury for the success of the fund for which we are specially appealing to-day that this meeting should be under the presidency of the Chief Magistrate of the City of London and the Chief Alderman of the City of London—a happy combination of justice and charity which ought to appeal to all men. Mr. Bonsor, you as treasurer know exactly the wants of the hospital, and your work is a labour of love, as I myself can testify with my own eyes. There are many controversies agitating the world at the present time, but there can be no controversy as to the merits of a great hospital. We all, in a public capacity and in a private capacity, know and feel that in cases of illness and sickness and accident, we want for those we love the benefit of the very best medical and surgical advice, and at Guy's Hospital the advice can be had. I have had compiled for me various statistics, which show how many have been the contributions of Guy's Hospital to medical and surgical science. The cases of Bright's disease and Addison's disease are instances in point. The rôle of the past contains such celebrated names, amongst the physicians, as Saunders, Babington, Bright, Addison, Golding-Bird, Sir William Gull, Moxon and Fagge. Dr. Pavy and Sir Samuel Wilks are still with us. Among the surgeons have been Sir Astley Cooper, Cock, Hilton and Durham. Mr. Howse, Senior Surgeon of the Hospital and President of the Royal College of Surgeons, is here to-day. When I tell you that Guy's keeps up a supply of more than two thousand medical men and dentists, for the personal service of the community in private life, and that large numbers of men who gain their experience at Guy's Hospital go from there to all parts of the English dominions, taking that knowledge and skill with them, you will recognise that the benefit that the hospital affords is far and wide. During the South African War, the hospital furnished a large contingent of qualified men, quite one hundred, a considerable number of whom, alas! will never return—they have given their lives for their country just as much as the soldier who perishes in the battle. Guy's Hospital has also considerably over one hundred nurses busily engaged in nursing in private houses in London and many other parts of the kingdom. Thirty-five Guy's Sisters and Nurses served or are serving with the Forces in South Africa, and others are serving in East and West Africa, in India, China, on the continent of Europe, and elsewhere, while a recent list gives no less than seventy important institutional posts throughout Great Britain which have been filled from Guy's Nursing Staff. I will mention to you a few things that struck me during my visit to Guy's Hospital. Mr. Bonsor most kindly volunteered to take me round the hospital, and there was no special preparation for the visit of a stranger. What struck me on arriving there was the love, the adoration, the sympathy that were apparent on every hand, and the wonderful way in which the Treasurer took an interest in everything and was known to everyone from nurses and patients to Staff and students; and I was told, by-the-bye, that the students of Guy's Hospital have still that exuberance of spirit which, in later life, developes the necessary vital energy so important to their profession. I was struck with the extraordinary gentleness of the sisters, by the loving-kindness of their faces. There are many interesting features of the hospital. There is, of course, every possible excellence of medical and surgical comfort. Personally, I was much interested in a room devoted to dentists. There were fifty chairs occupied by patients at the same time, and apparently the dental surgeons were executing their work with the greatest care and attention. Close by these were forty young men studying the art of making false teeth under a dental demonstrator. This seems a small matter when one thinks of the great tragedy of life and death, but still

the necessity of proper care of the teeth is one which appeals very much to those who have to earn their livelihood; and I believe I am correct in stating that Guy's is the only hospital in London which devotes so much attention to this branch of healing. What struck me also was the patience of those in the various beds, and the quiet and repose of the whole hospital, which proves that the discipline is excellent. So far I was perfectly satisfied, but I must tell you that there were many things that I did not like nor approve of, that to me are deplorable, I might almost say a calamity. The older buildings are beautiful in the exterior, like all edifices of the eighteenth century, but inside there are parts which sorely need that renovation which has effected such wonders so far as it has proceeded, and not least among the things which struck me as a crying need was better accommodation for nurses, who, tired after hours of watching and careful attendance, had to mount many stairs to reach their scattered, crowded and unsatisfactory dormitories. My Lord Mayor, you are perfectly right in thinking that it is the duty of the citizens of London to remedy all this. The Treasurer has told you in pathetic language that 200 years ago the founder of this hospital instituted the charity because he could not bear to see the sick poor dying without aid. Perhaps, as one belonging to a race still older than that of Thomas Guy, I may be allowed to quote a Rabbinical dictum which enjoins, "It is our duty to assist the poor, attend the sick and bury the dead of other creeds, for upon such amenities the peace of mankind is based."

THE HON. ALBAN GIBBS, M.P., in seconding the resolution, said: After the eloquent way in which this motion has been proposed, it is not necessary for me to delay you for any length of time, but I dare say you will bear with me while I express, on behalf of my father, Lord Aldenham, your late President, the great regret that he feels through not being able to be here to-day. Though at his advanced age he is not able to take such an active part in the management of the affairs of the hospital as he once did, his interest in it is unabated, and he desires as strongly as ever that it should continue to prosper. You have heard how for more than 160 years this great charity was dispensed without any assistance from outside, and you have heard that, owing to depression in land, those who managed the institution had to come to the public for help. When we were younger everybody felt that the "dirty acres," as the Irishman calls them, were the only safe things that you could invest in, for they can never run away. That is quite true, but unfortunately, we see that within the last forty years that the rents run away, and the tenants run away; and land in Essex without tenants is not a good thing to keep up a great hospital upon. There is one thing, however, which does not run away, namely, the people who need the hospital. All around the south of London, where the hospital is, you know perfectly well how enormously the population has increased. You have heard lately how much has been done for the spiritual welfare of those people—a very great thing to do—but you must remember that their physical welfare has also to be looked after, and Guy's Hospital is one of the great agencies which does look after that. It is you who have got to see that Guy's Hospital is not crippled in doing what it is intended to do. There are many ways in which you can help. I dare say you have, most of you, subscribed towards the institution; but many of you are directors of companies, and you probably are shareholders in companies. Can you not urge upon those companies that they should do something to help a great work like this? There are times when a thing is of national importance, and then I consider that limited companies should bear their share with other people. You may tell me that the hospital only concerns one class of the community. It is perfectly true that none of you whom I see before me may ask the aid of Guy's Hospital; but every one of you derive some variety of assistance from doctors, and what will be the use of those doctors to you if they have not had a proper training? Where will they get training except in hospitals such as Guy's, and how can those hospitals give them that training if they are not kept up to date, if they are not given the money to enable them to avail themselves of all modern facilities, and all modern knowledge? It does rest with you and the other citizens of London to see that Guy's Hospital is equipped as it ought to be equipped; it is your business, and I will ask you to attend to it. I will not keep you longer; but simply second the resolution.

MR. A. C. COLE: Speaking as I do as one of the Governors of Guy's Hospital, I should just like to emphasise what you have already heard—that in making this appeal, we who are connected with the hospital are all absolutely at one. You know our necessities and we ask your hearty co-operation. This country is at war, and we hope the day is not far distant when that struggle will be over. We Governors of this hospital cannot look for a termination of our struggle. We are engaged in a struggle with our two enemies—disease and accident—in multitudinous forms, and we hope that the result of this meeting will be that, before very long, we shall obtain that sum of six figures which will enable us to claim Mr. Morgan's £5,000. I would urge you to help us now with the sinews of war. To the young members of this meeting I would say, Do not be deterred because you cannot give as much as your seniors. We want also the hearty sympathy and co-operation of the younger citizens of London. There may be some here who cannot give anything at all now. We hope they will help us afterwards. I would simply now recall to you the words of a man well known in the City, a former Chancellor of the Exchequer, who, once addressing his audience, made use of these words: "Make your wills and do your duty." I will go beyond the five years which the Lord Mayor has put before you, and I will say to you all, do your duty when you make your wills and remember the needs of Guy's Hospital.

MR. CAUSTON, M.P.: In supporting the resolution before you, after the very able and elaborate speeches of the Lord Mayor and my friend, Mr. Bonsor, the energetic and able Treasurer of this hospital, for whom we are all indebted for the great work he puts into it, it is unnecessary for me to say much with regard to the hospital, but I want to say that we ought not to look upon Guy's as simply a South London institution, or even a London institution. This appeal ought not to be only to the citizens of London, but to the whole Empire, because Guy's Hospital is a great national institution. The nurses and doctors who proceed from Guy's not only go to the towns and cities of Great Britain, but to our Colonies, where we know great wealth is accumulated, and I think we might appeal to the Colonies to contribute towards this fund now being raised. As regards South London, we all highly appreciate the help it has given us, but Guy's Hospital is not only for South London, but for the metropolis and the rest of the country, because people who come from the country meet with accidents in the same way as those engaged in towns, and if they are in Guy's Hospital, there they can receive comfort and support. I hope, therefore, that this appeal will not be considered as merely an appeal to London, but to the whole Empire.

The resolution was unanimously carried.

MR. BONSOR then read the first list of donations to the Renovation and Building Fund as follows:—

FIRST LIST OF DONATIONS TO THE RENOVATION AND BUILDING FUND.

	£	s.	d.
H.R.H. The PRINCE OF WALES, K.G. (Ann. Sub.)	21	0	0
The Rt. Hon. the Lord Mayor	100	0	0
Alderman and Sheriff Bell	50	0	0
Mr. Sheriff Marshall	50	0	0
Raphael, The late H. L., Esq.	20,000	0	0
Morgan, J. Pierpont, Esq (when £100,000 has been subscribed)	5,000	0	0
Wills, Sir Frederick, Bart.	5,000	0	0
Raphael, Herbert H., Esq.	2,035	0	0
Raphael, Walter, Esq.	2,035	0	0
Beit, Alfred, Esq.	2,000	0	0
Goldsmiths' Company, The	2,000	0	0
Hospital & Medical School, Staff of the	1,783	0	0
Bank of England, The	1,000	0	0
Barclay, Perkins & Co., Messrs., Ltd.	1,000	0	0
Bonsor, H. Cosmo O., Esq.	1,000	0	0
Gordon, Robert, Esq.	1,000	0	0
Hambro, Everard A., Esq.	1,000	0	0
Heseltine, Powell & Co., Messrs.	1,000	0	0
"J. M."	1 000	0	0
Portman, Rt. Hon. Viscount	1,000	0	0
Rothschild, N. M. & Sons, Messrs.	1,000	0	0
Baring Brothers & Co., Messrs., Ltd.	500	0	0
Cassell, Sir Ernest, K.C.M.G.	500	0	0
Courage & Co., Messrs., Ltd.	500	0	0
Debenham, Frank, Esq.	500	0	0
Goshen, C. H., Esq.	500	0	0
Howse, The Rev. Walter	500	0	0
Lafone, Henry, Esq.	500	0	0
Morris, J., Esq.	500	0	0
Rothschild, Hon. Lionel Walter, M.P.	500	0	0
Speyer, Brothers, Messrs.	500	0	0
Watney, Claude, Esq.	500	0	0
Raphael, E. L., Esq.	300	0	0
Stern, Edward D., Esq.	300	0	0
Bass, Ratcliff & Gretton, Messrs., Ltd.	250	0	0
Benyon, J. Herbert, Esq.	250	0	0
Cole, A. C., Esq.	250	0	0
Goodhart, Dr. J. F.	250	0	0
Phillips, Lionel, Esq.	250	0	0
Wedd, Jefferson & Co., Messrs.	250	0	0
Wernher, J., Esq.	250	0	0
London & County Banking Co., The, Ltd.	210	0	0
Marson, the late T. F., Esq.	210	0	0
South Metropolitan Gas Company, The	210	0	0
Wigan, Sir Frederick, Bart.	210	0	0
Barclay, Robert, Esq.	200	0	0
Cohen, Alfred L., Esq.	200	0	0
Hankey, R. A., Esq.	200	0	0
Aldenham, Rt. Hon. Lord	105	0	0
Barclay, Charles, Esq.	105	0	0
Brown, Shipley, & Co., Messrs.	105	0	0
Charrington, J. D., Esq.	105	0	0
Czarnikow, C., Esq.	105	0	0
Gillett, G. E., Esq.	105	0	0
Gilliat, John S., Esq.	105	0	0
Henderson, Alex., Esq., M.P.	105	0	0
Hunt, Jackson, Esq.	105	0	0
Livesey, G., Esq.	105	0	0
Morley, Howard, Esq.	105	0	0
Morley, S. Hope, Esq.	105	0	0
National Provincial Bank of England, Ltd., The	105	0	0
Price and Pierce, Messrs.	105	0	0
Surrey Commercial Dock Company, The	105	0	0
Vivian Gray & Co., Messrs.	105	0	0
Ashcombe, Rt. Hon. Lord	100	0	0
Bentinck, Lord Henry, M.P.	100	0	0
Bevington, Colonel S. B., J.P.	100	0	0
Biddulph, M., Esq.	100	0	0
Clive, General E. H.	100	0	0
Cottesloe, Rt. Hon. Lord	100	0	0
Dobree, Bonamy, Esq.	100	0	0
Eno, J. C., Esq.	100	0	0
Gull, Sir W. Cameron, Bart.	100	0	0
Huth, Frederick, & Co., Messrs.	100	0	0
Johnston, R. E., Esq.	100	0	0
Leach, John George, Esq.	100	0	0
Lloyd, Harry, Esq.	100	0	0
Lucas, Colonel F. A., M.P.	100	0	0
Marks, Daniel, Esq.	100	0	0
Martin, M. Trevelyan, Esq.	100	0	0
Mason, Thomas, Esq.	100	0	0
Prudential Assurance Company, Ltd., The	100	0	0
Soper, William, Esq. (in memory of Hugh Soper)	100	0	0
Tennant, Sir Charles, Bart.	100	0	0
Tennant, Sons, & Co., Messrs. C.	100	0	0
United Charities of St. Olave and St. John, The	100	0	0
Vavasseur, Josiah, Esq., C.B.	100	0	0
Clutton, Wm. J., Esq., J.P.	52	10	0
Spratt's Patent, Ltd.	52	10	0
Collett, Sir Mark W., Bart.	50	0	0
Dawkins, C. E., Esq., C.B.	50	0	0
Down Bros., Messrs.	50	0	0
Harding, Geo., & Sons, Messrs.	50	0	0
Harrison, Gen. Sir R., K.C.B., C.M.G.	50	0	0
Hubbard, The Hon. Evelyn	50	0	0

	£	s.	d.
Leach & Co., Messrs., Ltd.	50	0	0
Leven and Melville, Rt. Hon. Earl of	50	0	0
Maynard, Miss	50	0	0
Merry, Archibald W., Esq.	50	0	0
Palmer, Samuel, Esq.	50	0	0
Reiss, Julius A., Esq.	50	0	0
"Restitutio"	50	0	0
Hunt, Miss	31	10	0
Dickinson & Co., Ltd., Messrs. John	26	5	0
Field & Sons, Messrs.	26	5	0
Stone, J. & Co., Messrs.	26	5	0
Barclay, Hanbury, Esq., J.P.	25	0	0
"C.R."	25	0	0
Denny, Charles, Esq.	25	0	0
Hutchings, E. J., Esq., F.R.C.S. (collection)	25	0	0
James, William D., Esq.	25	0	0
Laing, Captain M. A.	25	0	0
Locke, John Henry, Esq.	25	0	0
"M.C.B."	25	0	0
Girdlers' Company, The	23	0	0
Charrington, Sells, Dale, & Co., Messrs.	21	0	0
Haywood & Sons, Messrs.	21	0	0
Holloway Bros., Messrs.	21	0	0
Mellor, Colonel J. J.	21	0	0
Musker, John, Esq.	21	0	0
Weston, James, Esq.	21	0	0
Benson, James, W., Esq.	20	0	0
Fremantle, Hon. Sir Chas. W., K.C.B.	20	0	0
Lushington, E. H., Esq.	20	0	0
Norman, F. H., Esq.	20	0	0
"Old Guy's Man"	20	0	0
Saddlers' Company, The	20	0	0
Townsend, John, Esq., J.P.	20	0	0
Burton, Dr. H. C. (collection)	14	19	0
Gilbert, Dr. P. F. (collection)	14	10	0
Lovegrove, Dr. C. (collection)	12	4	0
Blofeld & Son, Messrs.	10	10	0
Docwra, John W., Esq.	10	10	0
Hollams, John, Esq.	10	10	0
Lazarus Bros., Messrs.	10	10	0
Lazarus, Simeon, Esq.	10	10	0
Rochester, Rt. Hon., Lord Bishop of	10	10	0
Sillem, Augustus, Esq.	10	10	0
Wallach, Heumann & Co., Messrs.	10	10	0
Williams, Alfred & Co., Messrs.	10	10	0
Acland, Sir C. T. Dyke, Bart.	10	0	0
Appleton, W. K., Esq.	10	0	0
Battersby, Frank, Esq.	10	0	0
Bayley, Edric, Esq.	10	0	0
"J. C."	10	0	0
Maitland, A. C. R., Esq.	10	0	0
Morgan, G. Vaughan, Esq.	10	0	0
Otter, R. H., Esq.	10	0	0
"S. S. C."	10	0	0
Floyd, Dr. S. G. (collection)	7	0	0
Cardin, Dr. H. (collection)	6	0	0
Fisk, Dr. Edward	6	0	0
Barham & Marriage, Messrs., Ltd	5	5	0
Barnes & Co., Messrs., Ltd.	5	5	0
Barron, The Misses C. & G.	5	5	0
Cater, J. J., Esq.	5	5	0
"E. G."	5	5	0
Farmiloe, T. & W., Messrs., Ltd.	5	5	0
Gill, Alfred, Esq.	5	5	0
Godden, Wm., Esq.	5	5	0
Harris, Dr. Robert	5	5	0
Haslett, G., Esq.	5	5	0
Hill, W. E. & Son, Messrs.	5	5	0
Kent, Edward, Esq.	5	5	0
Light, J., Esq.	5	5	0
Link, J. D., & Son, Messrs.	5	5	0
Liversidge, J., Esq.	5	5	0
Montefiore, Mrs.	5	5	0
Renton, G. H. & Co., Messrs.	5	5	0
Scrymgour, W. H., Esq.	5	5	0
Tallow Chandlers' Company, The	5	5	0
Watkin, John W., Esq.	5	5	0
Waygood, R. & Co., Ltd., Messrs.	5	5	0
Whichelo, A. G., Esq.	5	5	0
Wild, James A., Esq.	5	5	0
Wilson, H. E., Esq.	5	5	0
Bradley, Lieut.-Col. J. D.	5	0	0
Charlton, William, Esq.	5	0	0
Colville, Capt. Hon. S. C., R.N., C.B.	5	0	0
Dowson, Walter, Esq.	5	0	0
Green, Mrs. W. H.	5	0	0
Lawford, H. F., Esq.	5	0	0
Moore, J. R., Esq.	5	0	0
Mortimer, Percy, Esq.	5	0	0
"Omicron"	5	0	0
Parker, Archibald, Esq.	5	0	0
Prier, Samuel, Esq.	5	0	0
Strouts, R. H., Esq.	5	0	0
Webb, Major Henry	5	0	0
Willans and Robinson, Messrs. Ltd.,	5	0	0
Billinghurst, J. H., Esq.	3	3	0
Collyer-Bristow, A. A., Esq.	3	3	0
Dickins, Mrs.	3	3	0
Killby, James, Esq.	3	3	0
Moore, Miss	3	3	0
Smith, H. C., Esq.	3	3	0
Walford, E. J., Esq.	3	3	0
Brooks, Dr. W. F. (collection)	3	2	6
Cadell, Dr. N. P. (collection)	3	0	0
Foot, Mrs.	3	0	0
Grant, Henry & Co., Messrs., Ltd.	3	0	0
"In Memoriam, C. D. H."	3	0	0
Robson, Dr. E. S. (collection)	2	10	0
"A. W."	2	2	0
Barringer, H., Esq.	2	2	0
Bisley, Messrs. H. and G.	2	2	0
Chatterton, J. H., Esq.	2	2	0
Clark, H. H. Gordon, Esq.	2	2	0
Dadabhoy & Co., Messrs.	2	2	0
Gamman & Co., Messrs. Edwin	2	2	0
Green, Cecil E., Esq.	2	2	0
"H. V. W."	2	2	0
Hughes, T. R., Esq.	2	2	0
Huxley, Barton and Sons, Messrs., Ltd.	2	2	0
Lambert, Major F. A. H., J.P.	2	2	0
Lazarus & Sons, Messrs. Lewis	2	2	0
London City & Midland Bank (Tooley Street)	2	2	0
Lonergan, Messrs. H. M. & E.	2	2	0
Marvin, G., Esq.	2	2	0
Newton & Co., Messrs. J. W., Ltd.	2	2	0
Ransom, Wm., Esq.	2	2	0
Ripley & Co., Messrs.	2	2	0
Robertson, J. A., Esq.	2	2	0
Shears, Rev. H.	2	2	0
Stanley & Co., Messrs. W. F., Ltd.	2	2	0
Streeton, Walter, Esq.	2	2	0
Sutton, Mrs.	2	2	0
Tallis, Messrs. D. & J., Ltd.	2	2	0
Trotman's (C. W.) Boiler Works	2	2	0
Walford, E. L., Esq.	2	2	0
Wilson & Co., Messrs. J.	2	2	0
Woods, Miss	2	2	0
Wright, T. R., Esq.	2	2	0

	£	s.	d.
Astle, W. G. Devon, Esq.	1	1	0
Brown, A., Esq.	1	1	0
Colwell, H., Esq.	1	1	0
Corblet, C. J., Esq.	1	1	0
Dixon, James, Esq.	1	1	0
Douce, Miss	1	1	0
Earl, A. E., Esq.	1	1	0
"E. M. M."	1	1	0
"E. P. F."	1	1	0
Hocken & Co., Messrs. R.	1	1	0
Holt, Hillier, Esq.	1	1	0
Kidd, C. N., Esq.	1	1	0
Macgillivray, E. J., Esq.	1	1	0
Molyneux, J., Esq.	1	1	0
Moon, E., Esq.	1	1	0
Parker, Thomas, Esq.	1	1	0
Prichard & Renwick, Messrs.	1	1	0
Stahlschmidt, E. W., Esq.	1	1	0
Thompson, Rev. & Mrs. H. P.	1	1	0
Thompson, W. J., Esq.	1	1	0
Ursinus, Mrs.	1	1	0
Watson, M. W., Esq.	1	1	0
Whittington, John, Esq.	1	1	0
Williams, Herbert, Esq.	1	1	0
"E. B. B."	1	0	0
Pilchers, Messrs., Ltd.	1	0	0
Wilkinson, T. H., Esq.	0	10	6

DR. FREDERICK TAYLOR: It is my pleasing duty to propose a hearty vote of thanks to the Right Hon. the Lord Mayor for his kindness in affording to us the opportunity of this appeal being made within the walls of the Mansion House, and also for his kindness in presiding at this meeting. The Lord Mayors of the City of London are well known and far-famed for their great hospitality in a number of ways, in none more so perhaps than in promoting, nay, *initiating* various charitable and patriotic movements, especially in reference to the relief of suffering humanity, not only in the City of London, but in different parts of the world. As one who has been connected with Guy's Hospital from my boyhood, I may perhaps be permitted to say that I endorse in every way everything that has been said by Mr. Bonsor and those who have spoken on behalf of this appeal. I may remind you in more detail than has been given of the various improvements in connection with medical and surgical science, of which I may mention especially better nursing, the necessary perfection in the sanitary arrangements, bacteriological science in respect of diagnosis and treatment by antiseptic surgery and the abundant improvements and alterations, structural especially, that have been necessitated. I may refer also to the immense requirements in the way of electrical departments and in that absolutely new department, skiagraphy or the Röntgen rays, a department, I believe, which has already cost, not only this hospital but every hospital in the Kingdom, a very large amount of money annually. Under these circumstances, therefore, I am sure you all, with me, feel indebted to the Lord Mayor for his kindness in assisting us on this occasion, and, as I know, for the very great deal of trouble he has taken, and the large amount of time he has spent in the promotion of this appeal. The Lord Mayor has also allowed himself to be nominated and elected as one of the Governors of the Hospital, and I am sure we shall all feel the advantage that will be derived from this new and important link in the chain of connection between Guy's Hospital and the City of London. His great business capacity and the great influence he has in the City will, we have no doubt, promote the interests of Guy's Hospital, not only in this year of his mayoralty but also, we hope, of many years to come. I have very much pleasure in moving this vote of thanks to the Right Honourable the Lord Mayor.

MR. HOWSE: I think I need scarcely say anything further regarding the wants of this hospital except it be one word as regards the very great increase in the amount of operating which we surgeons have to undertake in the present day, and the very inadequate accommodation provided in the hospital in the shape of operating theatres, where, owing to the enormous increase of operative surgery and the enormous change which surgery has undergone during the past thirty years, a large bulk of our time has to be spent. If any of you will come round our hospital, I think you will see for yourselves what a very large field for improvement there is in the shape of increased accommodation in the direction that I have named. That accommodation is absolutely imperative in the course of the next few years for the right carrying on of the work of the hospital. Then let me say how grateful we all feel to the Lord Mayor for the way in which he has supported this appeal. I speak on behalf of the Visiting Staff, and I am quite sure I also speak on behalf of the Resident Staff and the Nursing Staff when I assure the Lord Mayor how deeply grateful we all are for the way he has supported this appeal. May I also say how grateful we are for the interest which he, with the Lady Mayoress, has taken as regards the work of the hospital, having personally examined into the various details of the work of the institution, and showing great interest in it. The support of our hospitals is an integral part of the commercial life of great towns like London. I would venture almost to say that London could scarcely exist without its great hospitals. Putting it merely upon the most commercial basis, what does a great hospital provide? We provide in the first place assistance to the suffering poor and others. We attend to the accidents which are in all cases impossible to avoid in the life of a great city. Not only do we do that for the poor, but we also train and provide medical men to be sent out by the hundred, not into London alone, but into England generally or to our Colonies. Thirdly, we provide what is not of less importance at all, train a number of nurses who shall go out and attend the sick so as to ensure a more speedy recovery to health. I have much pleasure in seconding the motion.

The vote of thanks was heartily accorded.

THE LORD MAYOR: I thank you very much for this kind resolution which you have passed. It has afforded both the Lady Mayoress and myself the greatest gratification to see you here to-day. I can only hope and trust that our appeal may be thoroughly satisfactory, and that

ere many weeks are over, anxiety and doubt may be removed from the shoulders of the Governors, and that this grand work will still further develop even beyond our present ideas. I must take this opportunity, Mr. Treasurer, of thanking you and your colleagues for the honour you have conferred upon me by electing me as one of the Governors. I will do my best for the welfare of this great institution, but of course, as you know, I am a man rather busy with municipal work and Parliamentary work, but I will do my best. I should like, before sitting down, to emphasise what Mr. Cole said. We do not appeal only for the thousands and five hundreds, and hundreds and fifties. We want you not only to give freely and willingly and generously of the things which God has blessed you with, but to try and bring in those who can give their guineas and their half-guineas to support one of the noblest institutions in this realm. I speak as one who has had the privilege of pleading for other charities besides this, and can say that, what is most essential for a charity is a known annual income. I leave that with you to consider in going away to-day. Do not you, a would-be subscriber, think that because an amount is small it is not equally acceptable and eagerly sought for. And now, I thank you for your kindness in passing this resolution, and may God's blessing rest upon your efforts.

The meeting then terminated.

Types.

No. 2.—THE ACTOR.

"Oh, there be players that I have seen . . . . who have so strutted and bellowed that I have thought that some of Nature's journeymen had made men."—*Hamlet.*

I knocked timidly at his door.

"Come in. Oh, it's you," said a languid voice. The owner lay half-concealed in a large chair, with a paper-backed book in his hands. His lips moved rhythmically as he pondered over the words of his part.

"I want to talk to you about your Art," I said, trying to suggest by my speech that the word had a capital letter.

"Ah, my ART!" He smiled faintly, and then his face slid back once more into its expressionless glare.

"Do you believe that the stage has a future?" I suggested this as a means of inducing further talk. Usually there is no necessity for any inducement. He is generally hard to stop.

"A future? My dear fellow 'The ashes of an unforgotten past taste bitter in the mouth of Memory.'" There did not appear to be much *à propos* in this remark; I subsequently discovered that it was a snatch of the last "part" in which he had appeared.

"Did you do anything in the C. U. A. D.?" was my next attempt at elucidation.

"My dear fellow! I *was* the C. U. A. D." Then "Excuse me," with an elaborate gesture of careless old-time courtesy, and he left the room. A sound of vigorous brushing issued from next door, and he reappeared with a sleek and shiny poll.

"Do you consider that the medical profession serves as a good apprenticeship for the nobler profession of Art?" I enquired with some show of interest. He did not reply for the moment, but assumed his stock attitude denoting contemplation. "Genius finds all attainments congenial," he replied. "That is why I went on the stage."

"But are you content," I suggested, "to interpret the thoughts of other men? Will you not give to the world——" He interrupted me with a gesture which seemed strangely familiar. "I shall write," he said, dreamily, "I shall write a play. Some day, perhaps, all London will flock to see my interpretation of the hero. He will be a noble fellow—full of wheezes." The last few words seemed to come from a different person. Already my versatile host had slipped into his third rôle of low comedy. Like a flash, however, it passed, and he was once more languid and dreamy. His filmy eyes gazed wearily across the dull grey of the court-yard. A look of agony swept across his face, and he flung his arms out with a gesture of unutterable weariness. I am not slow, as a rule, to take a hint, and I gently made for the door, fearing to break in on his reverie. But on the instant he arose to his feet, and with his head thrown back and the same haughty stare on his pale face, waved me courteously to the door. In his own gigantic mind he was doubtless a Tree.

I thought he was only a stick.

THE BALLAD-MONGER.

Papers by Guy's Men.

Tortuosity of both Internal Carotid Arteries. By R. P. Rowlands, F.R.C.S., and R. H. J. Swan, M.B., B.S. Lond.—*British Medical Journal*, 11th January.

A "Send-off" Dinner.

ON Thursday, January 9th, a dinner was given to wish Mr. Pakes good luck in his future work as Government Analyst and Bacteriologist in the Transvaal. The Guy's Staff was well represented, and Dr. Stevenson who occupied the chair, in proposing the health of the guest of the evening, gave expression to his early impressions of that gentleman, which were far from favourable, and explained how gradually these unfavourable impressions had been smoothed away and replaced by feelings of sincere respect and warm affection. He reviewed Pakes' career at the hospital, enumerating many of his numerous successes and achievements, then passing on to that period when, his studentship being terminated, Pakes was considering what line he should adopt for his future work. He knew that in the future, in his new field of work, Pakes would reflect nothing but credit upon his old hospital, and he now called upon them all to drink to his health, long life and prosperity.

The toast was received most enthusiastically, and accorded musical honours.

Herr Professor GRUBER said: My poor English will not allow me to say much; in fact I can only express in a few words my thanks for the sympathethic remarks directed towards me. I am proud to have been able on occasions to teach something to some of the young physicians of England, and to such a good man as my dear friend, Washbourn, and also the hero of this evening, Pakes. All the Englishmen who have come to my laboratory have been industrious and highly instructed, and in fact, so good in every respect, that it was a privilege to become a friend to them. Besides their high scientific training, each one was a man in the best sense of the word, and I drink to the health of all English students.

Mr. PAKES said: I thank you all for the cordial and enthusiastic manner in which you have responded to the toast of my health, and I take this opportunity of explaining what you probably already know quite well, that the certain gentleman referred to by Dr. Stevenson is of course Dr. Stevenson himself. I will now crave your indulgence whilst I just briefly refer to some, at any rate, of the familiar faces of the friends I see gathered around this table. Dr. Taylor who taught me all I know of medicine. Then there is Mr. Lucas to whom I was first ward clerk and afterwards dresser, and so became one of the far-famed firm Lucasites, or as the leucocytes are the most important constituent of the blood, so the Lucasites are the most important firm in the hospital, and I thank him most cordially for coming to my dinner, another expression of the real cameraderie shown by Clemmy to his dressers. During his illness I was associated with Mr. Lane, but under him I fear I had not much to do, although during this period I saw him do the third laminectomy in Guy's and therefore in England. There is one, too, who is not here to-night, Mr. Jacobson—good old Pom as he is called in the hospital—who has ever been a good and true friend to me. Then Dr. Pitt, whose extensive knowledge of literature has led me to many of my little bits of work. I remember I once contradicted him, and more than that on a point of opinion, not of fact. I was wrong of course. My friend Stevens, who once said I was a disgrace to the "bloomin" hospital, he subsequently said he didn't mean it. Then there is Dr. Bryant, I forget that he ever taught me anything, and the ever smiling G. B. Smith. Then we have present two gentlemen under whom I was never privileged to hold appointments, I mean Dr. Brailey and Mr. Higgens. I once gave an anæsthetic to Mr. Higgens and he didn't seem in the least impressed by the manner in which I went about the work. He merely remarked in his sweetest terms, "are you going to give the anæsthetic?"—the patient did *not* die. Then old Freddy Hopkins, who unfortunately is no longer a colleague, but what has been Guy's loss has proved to be Cambridge's gain. Lastly, but by no means least, my colleague and teacher, Washbourn, I won't call him Dr. Washbourn, who gave me my first step in the face of, as I well know, much opposition. Prof. Gruber, of the University of Vienna, is here to-night. This is to me a great surprise, for I hadn't the remotest idea that he was even in England. Then, too, there are representatives from other hospitals, for strange as it may seem there are hospitals other than Guy's, our old friend the Coroner, Dr. Kiallmark, Ernest Clarke, Caiger, Lieut.-Col. Davies, and also of other professions, including my old friend Sharpe. Then Sichel, who is the culprit who drew my photo on the menu. I have not mentioned all, but I must not keep you any longer, but I do thank you, one and all, for this excellent send-off dinner you have given me, and your hearty wishes for my prosperity in the Transvaal, and you may rest assured that it will be my endeavour to perform nothing disgraceful to my brotherhood and my Alma Mater—Guy's Hospital.

Dr. WASHBOURN: After the excellent manner in which our Chairman has proposed the health of our guest this evening, I can only congratulate myself and yourselves that the toast fell to his lot and not to mine. The prosperity of the new colonies depends mainly upon the men who settle in them, and is assured if they are all as good as Pakes. Pakes was a student of mine in bacteriology nine years ago, and I was instrumental in persuading him to take up this subject as his life work. I find it an easy matter to persuade a man, or a woman for that matter, to do what he is already inclined to. When I told a colleague of the step I had persuaded Pakes to take, he said, "Poor fellow, I am sorry for him!" And when I asked the reason of this sympathetic remark, he said, "Why, there is no money in it." I knew that this would have no influence with Pakes, but at the same time I am very pleased to know that Mr. Pakes has now a post, the remuneration of which is good, though not perhaps commensurate with his real value. I cannot think that the few thousand miles of land and sea that will be between us and him will be a real separation. Picture Pakes journeying from the

Cape to Pretoria through the dusty brown sameness of the veldt, past block houses by which the railway runs till even he will think of the soldier who said that even butterflies in Africa were in khaki. In the distant land he will meet many old friends—Turner, Rogers, Davies and Hamilton, and I believe that in his laboratory, an old two-story brick building, he will be influenced by his surroundings till finally he becomes a pro-Boer. Doubtless our friend would like to know something of the habits of the people amongst whom he is to pass the next few years of his existence, and as illustrating the primitive customs and occasional childlike simplicity of these people I cannot do better than tell him the little anecdote of the visiting bishop who had only just gone out to Africa: The bishop, whose diocese was scattered over several hundred square miles, arrived late one night at a Boer farmhouse on a visit. As so frequently happens in Africa, the house was dropped down in the middle of the veldt, a hundred miles from anywhere. When the bishop had been admitted by the Boer farmer, the latter explained that the house was full up and that the only arrangements he could make for him for the night were either that the bishop should share the children's bed or that of the farmer himself. The bishop luckily selected the latter alternative, for when on the following day he discovered that the children were two ladies of some eighteen and twenty summers, he felt that the Boer's hospitality was more sincere than discreet; and I would warn our friend Pakes that the odour of sanctity that would shield a bishop from the breath of scandal would certainly prove ineffectual in the case of a mere bacteriologist, and I would suggest to him that "forewarned is forearmed."

Dr. PYE-SMITH in the course of his speech said: In that vast country where some reputations have been made, and fortunes both made and lost, we hope Pakes will make both the one and the other. The result lies on the knees of the gods. No one can compel fortune, not even a bacteriologist. Whether Pakes achieves fortune or not, he will do his best and gain the approval of his comrades.

Dr. STEVENSON then replied, and Mr. Pakes proposed the health of the two Secretaries, Eyre and Rowell, and were briefly responded to by the gentlemen.

Chapel News.

The Rev. L. B. Sladen, who has been Acting Chaplain of the hospital since January, 1899, resigned his appointment on December 26th. He is to leave England shortly to visit various centres in the Dioceses of Grahamstown and Bloemfontein.

The Bishop of Rochester, as Chaplain of the hospital, has nominated his Domestic Chaplain, the Rev. H. F. Le Fanu, to take Mr. Sladen's place. Mr. Le Fanu entered on his duties on January 5th.

Mr. Henry Taylor, who has for some time been connected with the Guy's Glee Club and Choral Society, has been appointed Organist, and began his work on Sunday, January 5th. There will no longer be a choir of boys in the Chapel, and the music will depend entirely on a voluntary choir from the congregation.

No one who took part in the service could fail to be impressed by the simplicity and reverence of Nurse Heygate's funeral in the Chapel on January 9th.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Masonic Lodge.

DEAR SIR,—I am told that a notice appeared in the GUY'S HOSPITAL GAZETTE relative to the formation of a Masonic Lodge in connection with Guy's Hospital. As an old Guy's man (1858–61) and a Past Grand Officer (P.G.D.), I shall be pleased to assist in the event of such a Lodge being in contemplation.—I am, yours truly,

Army & Navy Club, BELGRAVE NINNIS.
Pall Mall, S.W.,
6th December, 1901.

A Correction.

DEAR SIR,—You are paying me too great a compliment, surely, and assuming a sort of perennial youth for me when you consider it worthy of notice that I was appointed "Senior House-Surgeon" to a large hospital eighteen years after leaving Guy's. I wish I were as young as you insinuate.

The *B.M.J.*, with its huge capacity for mistakes, is of course responsible for the error, but I hoped Guy's remembered me well enough not to fall into the same error.

Please correct the misstatement and delete the words "Senior House" which occur on page 20.—And oblige, yours faithfully,

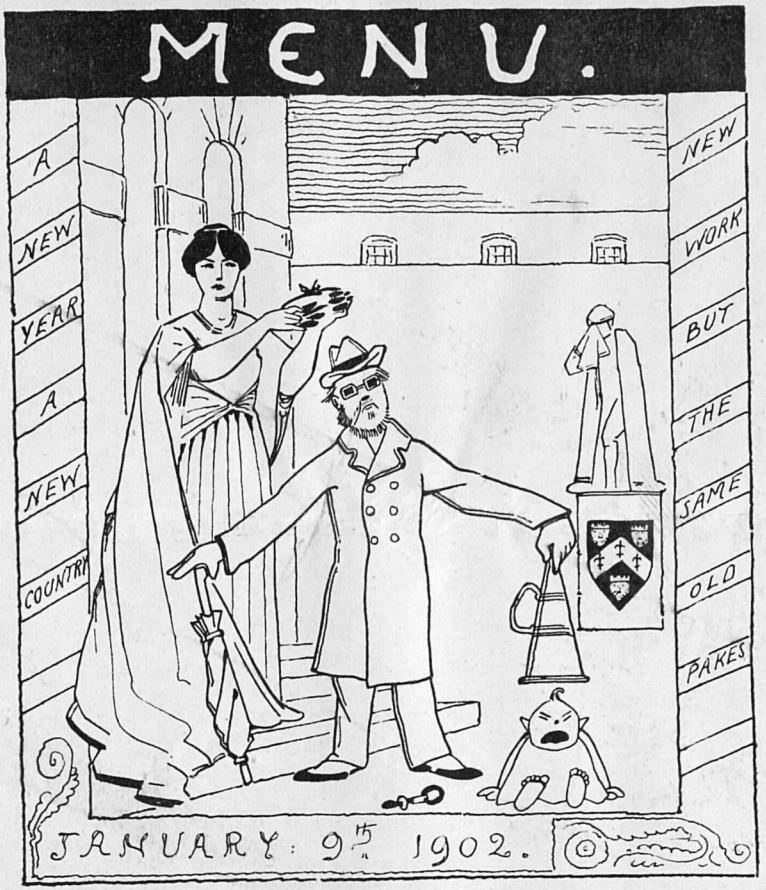
Roxeth House, WHEELTON HIND.
Stoke-upon-Trent,
January 6th, 1902.

Appointments.

CIVIL.

GOADBY, KENNETH W., L.D.S. Eng., D.P.H. Camb., has been appointed Bacteriologist and Lecturer on Bacteriology to the National Dental Hospital.

HIND, WHEELTON, M.D. Lond., F.R.C.S. Eng., has been appointed Senior Honorary Surgeon to the North Staffordshire Infirmary and Eye Hospital, *vice* W. D. Spanton, F.R.C.S.



Guys mourns the loss of Pakes.
What trouble, see, he takes
Suppressing of a bloomin' Public Nuisance
Hygeia crowns her pet,
Our perimeters we'll wet
To his health (the water's free from all pollutions)

(Translation).

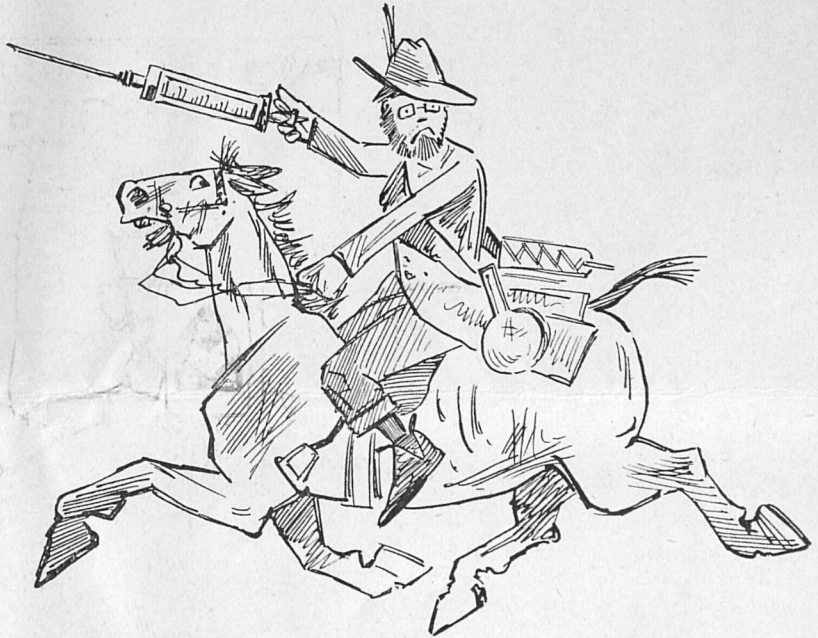
Dear De Wet.

Surrender un-
Conditionally.
Commandant Pakes
has been ordered out

Your old pal
Oom Paul.

P.S. Excuse blots - great haste.

G.S.



G.S.

"When Professor Pakes, mounted upon his favourite charger 'Antidiphtheria,' appears on the scene, the government feels confident that an important change will soon be manifest at the seat of war."—*Extract from Colonial Secretary's speech.*

THE "PAKES" DINNER.—Mr. Gerald Sichel's designs for the Menu.

Passim.

THE meeting held at the Mansion House on Wednesday last, in support of the Hospital Appeal, was an all-round success, and much encouragement may be drawn from it as regards the future. The first list of donations to the Renovation and Building Fund, issued at the close of the meeting, amounted to upwards of £64,000, a little more than one-third of the total amount required. Under all the circumstances of the time, this may be regarded as a very fair start; but the time to sit down and take rest is not yet.

A FULL report of the proceedings appears in our columns. A very large measure of gratitude is due to the Lord Mayor for the very hearty manner in which he has thrown himself into the cause of the hospital since the time when the meeting was first contemplated, and for the warmth of the appeal which he made on its behalf. And that gratitude must be extended to Mr. Leopold de Rothschild, the Hon. Alban Gibbs, Mr. A. C. Cole, and those other friends who pleaded the cause with such a genuine ring of sincerity and feeling.

THE proximity of the re-assembling of Parliament deprived the meeting of the probable presence of Lord Salisbury, and the otherwise certain attendance of Mr. Balfour, but as a Governor the latter was not content to simply excuse himself. His letter to the Treasurer, which was read at the meeting, is a powerful testimony of the merits and necessities of the hospital, and can hardly fail to bring material results. But what, perhaps, more than anything else gave to the meeting its tone of cheerfulness and confidence was the munificent donation of £5,000 from Sir Frederick Wills. This came in the form of a surprise packet. Sir Frederick being too unwell to attend, sent his cheque along to the Lord Mayor, and it was not until the last minute that even the hospital authorities knew what was in store. It is not the first experience that we have had of the generosity of this worthy Governor of the hospital, but his latest act, coming at a critical moment, is the sort of encouragement that turns possible defeat into certain victory.

BUT there is still a long row to hoe, and even when the £180,000 has been secured, there still remains that necessity, which the Lord Mayor so rightly insisted upon, of making the annual income of the Hospital safe and sufficient for the proper maintenance of the establishment. As the text of the Appeal points out, help can be rendered to the Hospital in one or more of three forms, viz. :—(*a*) By a donation to the Renovation and Building Fund. (*b*) By a donation or bequest to the Re-endowment Fund. (*c*) By a donatiou or subscription to the Sustentation Fund. The choice is wide enough to permit of everyone having ties to the Hospital doing something, not personally, of course, but by directing the benevolence of others towards Guy's Hospital. In the lives of most of us, there will occur from time to time opportunities for doing this without offence.

THE "send-off" dinner to "our old friend Pakes" on his recent Government appointment, given at Pagani's Restaurant, on Thursday, January 9th, was from start to finish a splendid success. The Staff turned out in great force, and the list of guests included many well-known names. The speeches were frank, friendly, and free—a most welcome change from the stiff studied orations too frequently delivered on such occasions. Dr. Stevenson naturally occupied the chair and proposed Mr. Pakes's health, which was drunk most enthusiastically to musical honours. The guest of the evening was in great form and gave a most characteristic speech, full of witty references to his many friends present. Herr Professor Gruber spoke in praise of English students in general, Dr. Washbourn and Mr. Pakes in particular. Dr. Washbourn told a story with a moral, which is not necessarily a moral story, and Dr. Pye-Smith referred to the gods. The menu designed by Mr. Gerald Sichel, a reproduction of which we publish as a supplement in this number, we need hardly say, was a triumph of artistic and poetic genius. The portrait of "Professor Pakes

mounted upon his favourite charger 'Anti-diphtheria,'" was most happy. In conclusion, we cannot do better than quote the lines from the menu :—

"Guy's mourns the loss of Pakes
What trouble, see, he takes
Suppressing of a bloomin' Public Nuisance
Hygeia crowns her pet
Our perimeters we'll wet
To his health (the water's free from all pollutions)."

A BRIEF announcement in the *Times* of Friday, January 10th, to the effect that Dr. Poole, Surgeon to the Legation at Pekin, had died from enteric fever, meant a great deal to many of our Guy's men. Wordsworth Poole was a man of whom we might be justly proud. He was a man of many achievements, and beside being brilliant in his profession, had undergone many hardships and had seen much fighting on the Niger in years past, and more recently in the siege of the Legations at Pekin. He was given up as lost with many others at the latter place, but came through safe and sound. We hope to publish an obituary notice in our next issue, the number of incidents in his adventurous career making it an impossibility to obtain a notice worthy of him in time for the present GAZETTE.

IT is with great regret that we learn that Nurse Heygate succumbed to enteric fever in Miriam ward on Sunday, January 5th.

ALTHOUGH at present we are unable to publish an exact balance-sheet of the Out-Patients' Tea accounts, we understand that while no money was spared to give the children their hearts' fill of pleasure, there is still a considerable sum left unspent. The committee thought it would be most appropriate if some of this surplus should be given to endow a cot for the coming year. They have every hope and expectation that, having started this most worthy project, future subscribers to the fund, far from relaxing their efforts because of the fortunate excess this year, will be stimulated to do their utmost to carry it on, and if possible to extend its scope.

THE December number of *Treatment* contains a most timely and useful article by Dr. H. Meredith Richards, Medical Officer of Health for Croydon, giving the cardinal points in the symptoms and diagnosis of small-pox. The value of the paper is considerably enhanced by several strikingly clear photos of discrete, confluent, hæmorrhagic and modified small-pox.

SIR SAMUEL WILKS, writing in the *Medical Magazine* for January, on "The Science and Art of Medicine," quotes some passages from a book written by the Rev. John Wesley, on "Primitive Physick, or an easy and natural way of curing most diseases." Though many of his ideas on this subject were quaint, there was, as Sir Samuel says, much truth in his appeal for less "building of Physick upon hypotheses." While Wesley advocated a simple cure for each disease, he was careful only to prescribe harmless drugs, "The four Herculean medicines, Opium, the Bark, Steel, and most of the preparations of Quicksilver. These are far too strong for a common man to grapple with."

SINCE December 9th the whole of the power required for the electric light used in the hospital has been supplied by our own plant, and at the present time we are wholly dependent on it. The excellent light all through Christmas week was a pleasing change from the almost complete failure that so frequently laid the hospital in semi-darkness in preceding winters, when lamps of all descriptions had to be hurriedly requisitioned during the early hours of the evening.

The meeting of the Debating Society to be held next Saturday will be the last occasion on which Mr. Pakes, who, as everyone knows, has done so much towards placing the society on its present firm basis, will be able to take the chair before his departure to South Africa. It is hoped all men will do their best to make the evening a success, and let Mr. Pakes's last impression of the Society be the memory of one of the brightest, keenest debates at which he has ever presided.

THE annual dinner of the Dental Society will be held at the Hotel Cecil, on February 8th, at 7 p.m. Tickets, price 6s., may be obtained of the Hon. Sec., Mr. T. Spiller. Mr. Dowsett will take the chair, and no doubt the function will be as big a success as it has been in former years.

IN another column we publish a letter from Inspector-General Ninnis offering his assistance in the proposed formation of a masonic lodge connected with the hospital. We are not acquainted with the exact steps that up to the present have been taken in this matter, and should be pleased if any of our readers could inform us how the question now stands.

GUY'S men will be glad to hear that Dr. John Tanner has been elected on the medical staff of the Royal Society of Musicians, on the resignation of Sir Samuel Wilks.

AN apology is due to Mr. Wheelton Hind for the unfortunate mistake that occurred in our last issue, when we announced in the list of appointments that he had been appointed *Senior House* Surgeon to the North Staffordshire Infirmary and Eye Hospital. Of course it should be "Honorary Surgeon."

WE are pleased, not to say flattered, to see that the editor of the *London Hospital Gazette* has deemed one of the "Letters from a Far-off Country," recently appearing in these columns, worthy of reproduction in his paper.

ON Saturday, January 4th, the First XV., in spite of the effects of the Christmas vacation, ran up a long score against the Old Leysians, coming out winners by 3 goals and 4 tries. The weather was of the worst, and the greasy stata of the ball and the ground had its effect on the passing of our outsides. Alcock and Payne were away, and the remainder were not in the best of form, the passing being very poor, even when the extenuating circumstances of the weather were considered. The forwards played up well, and are better than some of our critics would have us believe. Strict training must be commenced at once, and we shall then have one of the best teams we have ever put into the field, and we trust that its chances may not be marred by over-confidence.

THE First XI. is an improved side, and have opened the new year well with wins of 6 to nil and 2 to nil over the Old Eastbournians and Townley Park respectively. The forwards are better, and we hope they may take last year's lesson to heart, and learn that a hard, vigorous style of play is almost as good a one for a Hospital Cup Tie as a pretty combination, and that a healthy combination of the two is ideal.

THE second teams have not yet reappeared, the Second XV. having an enforced period of idleness, owing to lack of fixtures, while the numerous scratchings in the Second XI. have caused the match to be abandoned. With the quantity of material we have this year, it should be no difficult task to have a really good team for the Junior Inter-hospital Cup, and it is to be hoped that men may shew more keenness as the time for the ties approaches.

From the Gazette's Special Pathologist.

T. L. J., CHEADLE.—This specimen contained a considerable number of tubercle bacilli, with occasional clumps.

H. A. L., SWANSEA.—This specimen contained a fair number of tubercle bacilli occurring both singly and in clumps.

H. V. R., FORDINGBRIDGE.—The tubercle bacilli was not found in this specimen.

X. Y. Z., HASTINGS.—This specimen contained a small number of tubercle bacilli.

F., RICKMANSWORTH.—The urine contained a large amount of sugar, the presence of which was confirmed by the Phenyl-hydrazine and fermentation tests.

H. V. R., FORDINGBRIDGE.—The Tinea Tonsurans was not found in these hairs.

PATHOLOGIST.

Appointments.

SCOTT, RICHARD, J. H., F.R.C.S. Edin., has been appointed Honorary Consulting Surgeon to the Royal United Hospital, Bath.

SPON, H. J., M.R.C.S., L.R.C.P., D.P.H., has been appointed Surgeon-in-Ordinary for the St. Saviour's District of the Royal South London Dispensary.

Typhoid Fever.

CLINICAL LECTURE BY DR. WASHBOURN.

December 7th, 1901.

GENTLEMEN,—I have an interesting series of cases of Typhoid Fever to read to you to-day.

The first case is that of a boy, nine years of age, who was admitted on November 21st, the history of whose illness is this: He had been fretting ever since his mother's death, three weeks before admission. On the 17th (four days before admission) he complained that his legs ached; he also complained of headache and pain in the stomach. He was put to bed, where he remained up to the time of admission. The doctor who attended him at his home said that the patient had pleurisy and bronchitis. The boy was restless and feverish, and sick on the 20th. The bowels had been opened daily; but yesterday he had diarrhœa six times. He was sent up to the hospital by the doctor with the diagnosis of pneumonia.

On admission, the temperature was 103·8°, pulse 104. The skin was very hot and dry. There was no herpes about the face. The respirations were rapid; there was occasional cough; both sides of the chest moved normally; there was dulness at the left base from the spine of the scapula, and there was also an impaired note in the left axilla. On auscultation, there were mucous râles and rhonchi over both lungs, and at the left base there was deficient air entry, bronchophony, pectoriloqy, and fine crepitations. There was nothing special about the circulatory system. The abdomen moved well on respiration. The patient complained of some abdominal tenderness. The bowels had been opened six times yesterday. On inspection, the motions were semi-fluid, and of a light yellowish colour, with some undigested curds. Urine, sp. gr. 1018, with a trace of albumen; no diminution in the chlorides.

Summarising the case it comes to this: About three days before admission he was seized with headache and pain in the stomach; he had a cough, and on the day before admission he suffered from diarrhœa. When admitted he had a high temperature, rapid respirations, and he had signs of consolidation at the left base.

The first question to consider is the diagnosis. At first sight it would appear that the boy was only suffering from pneumonia. He was taken ill a few days before admission. He was seen by his doctor at home, who thought he was suffering from pneumonia. On examination, he was breathing rapidly, and he had signs of consolidation at one base. We were, however, not satisfied with the diagnosis of pneumonia, and for the following reasons: In the first place, he had some other symptoms. He had suffered from diarrhœa. Diarrhœa sometimes occurs with pneumonia, but it is not a very common symptom, certainly in the early stage. Diarrhœa, when it occurs in pneumonia, generally occurs late. Although I do not see any special note about it, I remember on looking at the abdomen, that I noticed it was a little full, and I thought I could feel the spleen. The general condition of the boy, somehow or other, suggested to my mind that he was suffering from typhoid, and I came to the conclusion that he was suffering from typhoid as well as pneumonia.

We will see how far the course of the disease bears out the original diagnosis. For thirteen days after admission the temperature continued at about 103°, and then it fell gradually to normal. It did not come down like an ordinary case of pneumonia by crisis, but gradually, and it reached the normal on the thirteenth day after admission, which was about the sixteenth day after he was first definitely taken ill. That was a long course of pyrexia for an ordinary uncomplicated case of pneumonia, in which the pyrexia usually lasts about eight days and then comes down suddenly to normal.

On one occasion we saw a spot on the abdomen, which, although not absolutely typical of typhoid, was nevertheless very suggestive.

Again, the spleen became enlarged, and the spleen, as a rule, is not enlarged in pneumonia when uncomplicated.

Moreover, the blood was examined several times, and there was never any marked leucocytosis; the leucocytes were about 10,000 per cubic millimetre, and that for a boy of his age is not an excessive number. You will remember

I told you last time that in favorable cases of pneumonia there is generally marked leucocytosis. In typhoid, on the other hand, leucocytosis is absent, and consequently the counting of the white corpuscles is of use to you in diagnosis.

Another method of examining the blood, in order to diagnose typhoid fever, is by the agglutination test. We tested the serum to see whether it agglutinated the typhoid bacillus. The blood was examined on the 23rd (three days after admission) and on that occasion it gave the typhoid test in a dilution of five per cent., but it failed to give an agglutination in a dilution of half per cent. In examining the blood with the agglutination test, you want not only to see whether the serum agglutinates, but in what dilution it agglutinates. If the serum agglutinates in a dilution of five per cent. that is a fairly good reaction and rarely occurs except in typhoid. If it agglutinates in a much higher dilution, such as half per cent., this is much stronger proof of the case being typhoid. But in any case you must only look upon this agglutination test as one of the signs of typhoid fever, just in the same way as you look on enlargement of the spleen or the presence of spots, and the more marked the agglutination the stronger the evidence of typhoid fever. To-day, December 7th, the condition of the lung has cleared up and the patient is recovering, There was then good evidence that the patient was suffering not only from typhoid fever, but also from pneumonia, both occurring at the same time.

We went still further in this case and made enquiries as to the family history. We found that the father was alive and healthy. The mother died three weeks before the patient was admitted, and the cause of death was stated to be pneumonia and tuberculosis, and she died after an illness which lasted three weeks. Another child, five months old, died five days after the mother, and the cause of death was stated to be bronchitis. A sister of the patient, aged twelve, is at the present time in Mary ward convalescent from typhoid fever. Subsequently we had another sister admitted into Clinical ward suffering from typhoid.

As regards the mother, she is stated to have died from pneumonia and tuberculosis after a three weeks' illness. Three weeks is a long period for death to occur from pneumonia, and it is a short period for a patient to die from tuberculosis. So that it is probable that the diagnosis was incorrect. As to the infant, she is stated to have died of bronchitis, and that might very well be. Children of five months frequently die from bronchitis and broncho-pneumonia, and it is quite likely that the death might be put down to bronchitis, even if there was pneumonia present. The further history of infection made it probable that the cause of death was really typhoid fever. We thought the mother had not died of bronchitis, but most probably of typhoid fever, accompanied with a good deal of bronchitis. Three weeks is just the period at which a patient dies of typhoid fever, and if the signs of bronchitis in this particular case were very prominent the typhoid fever might have escaped recognition.

We looked up the notes of the other sister who was admitted into Mary ward under Dr. Pitt. She was a girl, eleven years of age, who had apparently always enjoyed good health, except for an occasional cold and cough. She was quite well until October 7th, when she contracted a cough, and was admitted on the 28th. When the cough was first contracted the mo her was ill and this girl used to visit the sick-room several times a day. On October 25th the patient complained of pain in the right flank, and her appetite was poor. On the 26th she felt so unwell that she had to go to bed. She felt better on the 27th and got up, but later in the day she became much worse. The doctor was called in, and he advised that she should be sent to the hospital. On admission, her temperature was 105·2°, pulse 124, respiration 67. She was well nourished and well grown. She was in a highly feverish state, her face was flushed, the eyes red, the skin dry and hot. A loose cough troubled her, and the sputum was gluey and brownish. She complained of pain in the right side and tenderness all over the chest, both sides of which expanded equally, or, if there was any difference, the left a little better than the right. The breathing

was rapid—67—and peculiar, each inspiration being followed by a pause, and each expiration being immediately followed by an inspiration, a form of breathing which frequently occurs in children. The note was good over the chest. There was no perceptible dulness. Râles and rhonchi were present all over the chest; in front the sounds were chiefly sibilant and sonorous; behind there were mucous râles and patches of consonating râles below; crackling râles were heard in the left base in the axilla line. There was no herpes. The bowels have been irregular recently, diarrhœa alternating with constipation. The tongue was coated. There was nothing special about the circulatory system, no adventitious sounds; the urine was normal and contained no albumen. The temperature kept up until she had been in for about thirteen days, and then, just as in the first case that I read to you, the temperature gradually came down to normal. Whilst she was in, she had diarrhœa, and the spleen was felt on several occasions. The blood was examined and it gave an agglutination in as high a dilution as 1 in 200 with the typhoid bacillus. The patient gradually got well.

To summarize: she was a child, eleven years of age, who for three weeks suffered from cough, weakness, and irregularity of the bowels. For the four days preceding admission she had pain in the chest, on the right side. When admitted she was in high fever, with râles and rhonchi all over the chest, and rapid breathing. Two days after admission the spleen was palpable, diarrhœa was present, with abdominal pain and tenderness, and the stools contained undigested matter. There was no rash. The blood gave a well-marked typhoid serum reaction, and the fever fell by lysis, and the patient got perfectly well.

There seems to be no question whatever about this case being one of typhoid fever. But, you notice, the lung symptoms were very marked. In fact, I understand, when she first came in they thought she was suffering from pneumonia. Although there was no definite dulness, yet there were consonating râles at one base, and all through the chest symptoms were a prominent feature.

Later on, on the 29th of last month, another sister was admitted. The history is as follows: On the 23rd November, she was noticed to have lost her appetite and to be lying about. She was sick on one occasion. The doctor saw her and sent her to the hospital. The bowels had been opened regularly, and there was no diarrhœa; the appetite was bad and she had suffered from cough, which was very troublesome. On admission, the temperature was 101°, respirations 24, pulse 132. There were numerous rhonchi and a few râles over the left chest behind, and a few over the right chest. The râles were consonating. There was no bronchial breathing. There were no spots. The abdomen was not unduly distended; the spleen could not be felt. Since the patient has been in, that is to say since the 29th, the temperature has continued raised, and to-day (about the ninth day) it is practically normal. No particular symptom has developed; the patient has simply suffered from fever without any very definite symptom. The blood was examined on the 30th and gave no typhoid serum reaction. We are having a second examination made because, as you know, the agglutination test is not always given at every stage of the disease, and it may be that when she was admitted it was too early a stage for the agglutination to occur. But we have no doubt that this patient also is suffering from typhoid. (Subsequently she had a relapse which proved the correctness of the diagnosis.)

Now, you will see from these cases how very important it is to consider the etiology of every case. When the first case came in we might very well have considered it to be one of pneumonia, and have rested content with that diagnosis. But when we went into the history and found that the mother and a sister had died recently, that another sister was admitted into the hospital and found to be suffering from typhoid, and then, later, that another sister was admitted who had also typhoid—all this pointed very strongly to a diagnosis of typhoid in this particular case. It is always very important, where you are dealing with fever, or if you suspect the disease to be infectious, to make enquiries as to the occurrence of illness in the neighbourhood. This especially in the case

in schools or institutions. You are called to see a case of fever. The first thing to do is to find out whether there are any similar cases occurring in the same house, from which you may get valuable information. On the other hand, you must be a little careful, because one frequently notices mistakes made by paying too much attention to the history of infection. I heard of a case only the other day where a boy was seen who was suffering from scarlet fever. Shortly afterwards another boy in the same dormitory was taken with fever, and he was thought to have scarlet fever. As a matter of fact it turned out to be typhoid. Don't forget that two infectious diseases may exist in the same school or institution at the same time.

You will notice that there are some peculiarities about this outbreak of typhoid. The principle peculiarity is the marked affection of the lungs. In every case the symptoms in the lungs were most marked. The mother was supposed to have died from pneumonia and tuberculosis; one child was supposed to have died from bronchitis; the child who was admitted into Mary ward was at first thought to be suffering from pneumonia; the child who was recently admitted into Clinical has a great deal of bronchitis; and the child the notes of whose case I read to you first had definite consolidation of the lung.

You must remember that there are several kinds of pneumonia. There is the ordinary croupous or lobar pneumonia, due to the presence of the pneumococcus. Then there are pneumonias which are due to other micro-organisms, and are unconnected with ordinary croupous pneumonia. The typhoid bacillus itself may give rise to a form of pneumonia, generally a more or less lobular pneumonia; and the question arose in connection with this particular case, Was this patient suffering from two diseases—from acute lobar pneumonia and typhoid, or was the patient suffering entirely from typhoid, and was the pneumonia only one of the manifestations of typhoid poison?

That opens out the question as to whether the typhoid bacillus may not sometimes enter the body by means of the lungs. You know that the usual mode of entrance of the typhoid bacillus into the body is through the alimentary canal. The bacilli are swallowed with the food, and they enter the system through the lymphoid tissue. But it is quite on the cards that the poison may enter through the respiratory tract, that the bacilli may be inhaled, as occurs in other diseases—in, for example, plague. Plague is very interesting from the point of view of the way in which the infection occurs. In plague the usual mode of infection is for the bacillus to get into the body by means of some abrasion of skin. It then gets into the lymphatic glands and starts the ordinary type of plague known as bubonic plague. But under certain circumstances the bacillus may enter through the lungs, it may be inhaled and it then sets up a virulent form of pneumonia which at one time was not considered to have anything to do with plague, but which can now be definitely proved to be ordinary plague by a bacteriological examination of the lungs after death, or of the sputum during life. And a point of very great interest is this; if one case of pneumonic plague occur in a household, the other people, if they contract plague, generally contract the same form. The reason is very simple. The bacilli are coughed up by the patient suffering from plague in the sputum, then the sputum dries and gets into the air and the bacilli are easily inhaled by the other people. So that the probability is that where infection has occurred by one mode, the other persons who contract the disease will get the infection in the same way, and consequently get a similar type of disease. That is a very important general principle with regard to infective diseases.

Hence it is quite possible that all these patients may have contracted enteric fever by inhalation, which would account for the marked lung symptoms in each instance. But we cannot say for certain that this was the way in which the lungs were affected. It might have been that the whole family were weak in their lungs, and that consequently the brunt of the disease fell upon those organs. Anyhow, these cases will impress upon your minds the fact that in typhoid fever the lung symptoms may mask the ordinary features of the disease.

A Case of Gastric Ulcer with Tetany and Di-aceturia.

BY DAVID FORSYTH.

THOUGH by no means a common disease, tetany is well known as a result of certain affections of the gastro-intestinal tract. Of these, dilatation of the stomach is by far the commonest, but cases have been described in which the convulsions were due to acute gastro-enteritis, peritonitis, chronic diarrhœa, constipation, etc., but so far as I have been able to ascertain there is no record of a case of tetany complicating simple gastric ulcer. An ulcer in the pyloric region which cicatrises and so produces dilatation of the stomach is, of course, not infrequently found as the cause of tetany, and in these cases the convulsions are often of peculiar severity. But as a direct result of a gastric ulcer, with no intermediate dilatation of the stomach, tetany is unknown.

For this reason alone, the following case, which Dr. Perry has kindly allowed me to record, would be of exceptional interest, but in addition, it presents another feature which is but rarely seen. Acetone and di-acetic acid are occasionally found in the urine in various pathological conditions of the alimentary canal, including gastric ulcer. As a rule, the presence of these abnormal constituents in a case of gastric ulcer is correlated with no special symptoms, but rarely a sequence of symptoms arises resembling in a striking manner the toxic effects in diabetes mellitus. Thus, in the severer forms, the patient may be seized with abdominal pain, nausea, and vomiting; the respirations are increased, and drowsiness deepens into coma and epileptiform convulsions. In the slighter forms there are, in addition to abdominal pain, vomiting, severe headache and giddiness — symptoms which may easily suggest uræmia. A perusal of the following account will show that the patient has suffered from these toxic symptoms while under the care of her private medical attendant.

Ellen C., æt. 33, unmarried, a nursemaid, was admitted into Mary ward under Dr. Perry, on October 18th, 1901, for pain in the stomach. The family history shows that patient's mother has been in an asylum for some years suffering from "loss of memory."

Previous history.—In March, 1886, patient "broke a blood-vessel" in her stomach, and vomited a quantity of blood. From that time she enjoyed excellent health, till February, 1900, when she had diphtheria.

History of present complaint.—In July, 1900, patient was admitted to Woolwich Infirmary for pain after food, vomiting and flatulence; there was no hæmatemesis. She was discharged relieved after four weeks, but has ever since suffered from indigestion and flatulence. Six weeks before her admission to Guy's her pain, which was chiefly epigastric, grew worse, but she was not sick at all. Three weeks later she was attacked with severe abdominal pain, and the vomiting recurred and became almost continuous. Dr. Alexander, of Epsom, saw the case at this stage and in reply to my enquiries wrote that at the time he saw patient "there were decided uræmic symptoms—scanty urine, slight trace of albumen and a good deal of dyspnœa. She had several attacks of a convulsive nature . . . a general stiffening of the body with the upper extremities extended and thumbs turned into the palms of the hands. On two occasions I found a little sugar in the urine with sp. gr. 1035." In answer to a second letter, Dr. Alexander kindly stated that—

1. Patient had three or four convulsive attacks; sugar was found on the first day of attendance, *i.e.*, the day after her convulsions.
2. Dyspnœa lasted for first week of illness.
3. Patient was never comatose, but was drowsy.
4. Sugar was frequently absent from the urine.
5. Sugar and convulsions were both absent during the latter part of his attendance. On one occasion she vomited a tea-cupful of blood and mucus.

On admission. — Patient looks anæmic but well-nourished. Temperature 97·8°, pulse 100, respiration 48. The abdomen is slightly retracted and moves on respiration. There is intense hyperæsthesia and tenderness over the epigastric and left hypochondriac regions. There is no fulness in the epigastrium, the curvatures of the stomach cannot be seen; there is neither peristalsis nor succussion splash. The urine contains a body which feebly reduces Fehling's solution. Circulatory and respiratory systems normal.

Towards the end of the examination patient had a mild convulsive attack in which the wrists were slightly flexed, the thumbs bent into the palms of the hands, and the fingers flexed. It lasted only a few minutes.

Course of disease.—October 22nd. Acetone and di-acetic acid were present in the urine yesterday, but to-day are absent.

24th. Epigastric pain and tenderness persist. Patient has been placed on milk diet but vomits constantly. The vomit contains lactic acid, and the amount of free hydrochloric acid is diminished; no torulæ or sarcinæ. Temperature remains normal, but respirations are from 30 to 40 per minute; pulse normal. Last night patient had a distinct rigor lasting some minutes, but without any elevation of temperature. Treatment—Bismuth and morphia by the mouth, and rectal injections of the following—

Take of—Starch (raw)	2 ounces.
Whites of 3 eggs.	
Sodium chloride	40 grains.
Water to	8 ounces.

As an enema at 6 p.m.

Take of—Arrowroot	2 ounces.
Raw beef-juice	8 „

As an enema at 10 a.m. and 2 a.m.

25th. Attack of tetany this morning. The attack began with chattering of the teeth and a general shivering of the body. The face looked pinched and the lips and nose blue. Both hands began to tingle and grew purplish in colour; there was no œdema. In a few minutes the thumbs were flexed across the palms, which were hollowed, the fingers were flexed over them and

their tips pressed together. The wrists were strongly flexed, the forearms pronated and the elbows slightly flexed. The arms were closely adducted to the side. Simultaneously the legs were effected, the great toes being strongly extended dorsally, the others slightly flexed; the knees were flexed and tightly pressed against each other. All the joints involved were rigid, and attempts to move them caused much pain. Respiration 52, pulse slightly accelerated, temperature normal. The limbs were briskly rubbed and the attack subsided in about ten minutes, leaving a severe headache, which was increased by the slightest movement of the head.

November 10th. Nutrient enemata omitted. Vomits occasionally. Cannot take any food except liquids. Respiration about 24, temperature and pulse normal. Suffers much from insomnia, for which she has potassium bromide.

11th. Patient delirious last night; said she could not sleep for the number of little animals that rushed shrieking up and down the ward. Was quite rational this morning, but complained of severe abdominal pain and headache. At 11 a.m. another attack of tetany, similar to one on October 25th. Temperature afterwards rose to 104·4°, and patient lay in a heavy, drowsy condition. Diarrhœa.

12th. Morning temperature 103°; headache and drowsiness persist. Temperature regained normal by the afternoon.

18th. For last two days patient has been unable to take any food except milk and barley water, and even this caused much pain. To-day she was put direct on to fish and toast, without increase of pain. The urine has been free from di-acetic acid since October 24th.

19th. Patient again strange last night, attempting to get out of bed and seeing men forcing their way in through the windows. Severe headache this morning, drowsy and irritable. No signs of tetany. Trousseau's and Chvostek's symptoms absent. Acetone and di-acetic present in urine, together with albumin.

20th. Quiet night. Headache still persists. Hands became cold and blue this morning and fingers tingled, but no spasm occurred.

23rd. Tetany convulsion this morning lasting two and a quarter hours, similar to preceding, but all the toes flexed and crowded together, foot arched and ankle extended. Tendo-Achilles and popliteal tendons hard and prominent; muscles of limbs rigid; trunk not affected, but lips slightly pouted, corners of mouth drawn down, eye-brows raised, nostrils not dilated. Second attack 10.30 p.m.; more severe, patient crying out with pain. Spasm relieved by inhalation of A.C.E. with no recurrence as anæsthesia passed off.

24th. Severe headache and drowsiness. Muscles of arms and legs feel "as though they had been beaten," and are tender on pressure. Neither Trousseau's or Chvostek's symptoms have been obtained since admission.

25th. Di-aceturia and albuminuria have been present since 19th inst. Patient put on farinaceous diet (fish omitted) and salol gr. x. ter die given internally.

26th. No di-acetic acid, acetone or albumen this morning. Patient delirious last night, and has headache this morning.

December 1st. Patient doing well. No signs of tetany.

2nd. Di-acetic acid and albumen absent since 25th ult. Patient put on fish to-day.

3rd. Acetone and di-acetic acid reappeared.

9th. Patient got up after tea; 10 p.m., attack of tetany.

10th. Headache. Muscles sore, and ache. To remain in bed.

13th. Croupy cough. Attack of tetany 12 (midnight) relieved by inhaling A.C.E.

14th. Headache, drowsy.

18th. Acetone and di-acetic acid have been present since 3rd inst.

19th. Omit salol mixture. Continue fish.

20th. Attack of tetany 8.30 a.m.

21st. In same condition as after previous attacks. Di-aceturia persists.

Remarks.—Before discussing the case, it may be worth while to meet one possible objection to the diagnosis. The patient gives a history of having broken a blood-vessel in her stomach fifteen years ago, and it might be argued that she then had a gastric ulcer which has cicatrised, and that the present tetany is due to subsequent dilatation of the stomach. That this is not the case is proved by the fact that since her admission, repeated examination has failed to discover a single sign of dilatation.

A careful study of the case reveals many points of interest. To consider, in the first place, the attacks themselves. The typical attack began with delirium which passed off leaving a severe headache; after an interval of a few hours, the teeth began to chatter and there was a general shivering of the body. Closely following, or, to a certain extent, accompanying this, there was blueness of the lips and nose, and congestion of the hands; the fingers then began to tingle and in a few minutes the patient was seized with a typical and more or less painful tetany spasm. This lasted from ten minutes to two and a half hours, and left the patient in a drowsy condition and with an intense headache. The temperature was not raised but the respirations increased to over fifty a minute.

Risien Russell (Allbutt's System) says that, as a rule, there are no premonitory symptoms of an attack beyond the tingling, and the only cerebral disturbance he mentions is headache. This statement is borne out in the thirteen cases of tetany that have been in Guy's since 1888. No mental symptoms were seen in these, though in one (a case of phthisis under Dr. Newton Pitt in 1900) there was a history of loss of consciousness during one attack before admission. Similarly, none of the cases of tetany reported in the *Lancet* and *British Medical Journal* for the past twelve years showed mental symptoms. In the present case, since admission there have been in all, three attacks of delirium, and though

only one was followed by tetany, it must, I think, be admitted that on the two other occasions the same cause was at work, and the delirium is to be regarded as the premonition of an abortive attack of tetany. The same explanation must be given of the rigor on October 23rd and the tingling in the fingers on November 20th.

Another feature worthy of note is that at no time since her admission has the patient exhibited either Trousseau's or Chvostek's symptoms. Attempts to elicit these phenomena were frequently made both before and after the spasms, and also during the intervals between successive spasms, but never with success.

In seeking some cause for the spasms, attention was at first given to the presence or absence of acetone and di-acetic acid in the urine, since before admission the fact had been noted that a reducing body was present on the day following two attacks of tetany, but was afterwards absent. And at first it seemed as though the two conditions bore some relation to each other, for di-aceturia was observed from October 20th to 25th, and on the 23rd and 25th tetany occurred. The following day the di-acetic acid was absent and remained absent for a fortnight, during which time there were no further convulsions. On November 11th there was another attack, but unfortunately we did not obtain specimens of the urine from the 8th to the 12th, as patient was menstruating. From November 13th to 18th there was neither tetany nor di-aceturia, but from this latter date our attention was directed rather to the diet than to the urine. Why this was so will be apparent from the following table, in which I have summarised the results of the daily examination of urine made by Mr. F. P. Hughes, and compared them with the treatment and with the attacks of tetany.

An examination of this table is most instructive. From October 25th to November 18th (with the exception of the menstrual days above noted) there was neither acetone nor di-acetic acid in the urine and patient was on farinaceous diet. On November 18th she was put on fish and continued on it till the 25th November. During those seven days she had five attacks (or abortive attacks) of tetany, *i.e.*, more than she had had in the four previous weeks, and each day the urine contained acetone, di-acetic acid and albumen. The only possible conclusion was that the fish diet was in some way responsible for the attacks, presumably from the absorption of a toxic product of digestion. The fish was therefore at once stopped and an antiseptic line of treatment adopted. The next day the acetone, di-acetic acid and albumen disappeared and remained absent till December 3rd; there was no further tetany. On December 2nd fish was again ordered and the salol mixture continued. The following day the acetone and di-acetic acid re-appeared in the urine, and (the fish diet being continued) has persisted till now (December 22nd). But, as was hoped, there were no fresh attacks of tetany. The spasm on December 9th and that on December 13th must not be ascribed to the same cause as the earlier ones. On the 9th patient got up for the first time for over seven weeks; on the 13th she developed some laryngitis with a croupy cough, which worried her considerably. Each of these attacks should be, I think, ascribed to the particular incident of the day on which it occurred, for it is well known that a person suffering from tetany may have an attack induced by some cause (*e.g.*, emotion) other than that immediately causing the disease. These two paroxysms of spasm (of the 9th and 13th December) must

Date.	Diet and Medicine.	Attacks of Tetany.	Urine.
Oct. 18—Nov. 17	Farinaceous and nutrients Bismuth & morphia	Oct. 18. Tetany ... ... „ 23. Rigor ... ... „ 25. Tetany ... ... Nov. 11. Tetany (delirium, pyrexia and diarrhœa)	Oct. 19—24. Acetone and di-acetic acid. „ 25—Nov. 27. No acetone or di-acetic acid. Nov. 8—12. Menses. „ 13—17. No acetone or di-acetic acid.
Nov. 18—25 ...	Fish Bismuth and cocaine hydrochlorate	Nov. 19. Headache; delirium. „ 20. Tingling in hands. „ 23. Tetany. Tetany. „ 25. Delirium.	Nov. 18—25. Acetone and di-acetic acid. Albumen.
Nov. 26—Dec. 1	Farinaceous Salol and bismuth	— — —	Nov. 26—Dec. 2. No acetone, di-acetic acid or albumen.
Dec. 2—18 ...	Fish Salol and bismuth	Dec. 9. Tetany (after getting up.) „ 13. Tetany (laryngitis).	Dec. 3—21. Acetone and di-acetic acid.
Dec. 19—22 ...	Fish Omit salol and bismuth	Dec. 20. Tetany.	[The amount of urea excreted shows no obvious connection either with the tetany attacks or with the varying diet.]

not therefore be held to invalidate the explanation of the cause of the earlier attacks, which will be given immediately. The fish diet has been continued till now, but on December 19th, the salol mixture was omitted. On the following day patient had another attack of tetany —the first for about three weeks (neglecting the two attacks above excepted).

All these facts point undoubtedly to one explanation. The digestion of fish leads to the formation in the alimentary canal of some toxic product which, on being absorbed, acts as an irritant to some part of the nervous system, producing tetany. The same food also causes acetone and di-acetic acid to appear in the urine.

Two questions at once suggest themselves. What is the relation of this toxin to the di-aceturia, and what are the relations of each or both of these to the convulsions? In the first place, the di-acetic acid itself might be the toxin. If this were the case, so long as there was di-aceturia, the toxin would be circulating in the blood, and should therefore give evidence of the fact by producing tetany convulsions. But we have seen that for over a fortnight (December 3rd to 19th) there was a condition of di-aceturia without convulsions. Moreover, on October 25th there was an attack of tetany, yet the urine collected on that day contained neither acetone nor di-acetic acid. The di-acetic acid itself therefore cannot be the toxin, and the possibility of a toxic body which is not di-acetic acid but is excreted as such, being the cause of the attacks must be dismissed for the same reasons.

We have therefore to conclude that two bodies are elaborated in the alimentary canal and absorbed, one of which appears in the urine as di-acetic acid, the other, a toxin, acts as the immediate cause of the tetany spasm. A reference to the table reveals one other fact regarding this toxin which is of considerable therapeutic value. So long as salol is given by the mouth, the formation of this toxin is prevented (December 2nd to 18th), without the salol the toxin is formed, absorbed and produces its convulsive effect (November 18th to 25th, December 19th to 21st).

Another point that needs a moment's consideration is the presence of albumen in the urine from November 18th to 25th. This interval coincides with the period during which fish was being given, and was producing di-aceturia. The usual explanation of the albuminuria in tetany is that the toxin, while being excreted by the kidneys, injures the renal epithelium, and so allows the passage of albumen. But in this case there are two objections to the theory. If the toxin is excreted by the kidneys, it must have been excreted, not only when there was albuminuria, but also on other occasions, when the urine was free from albumen. Again, if the albuminuria is due to some injury to the epithelium, one would not expect the albumen to suddenly disappear unless the toxin ceased to be formed; the injury would take some little time to repair, and during that time albumen would pass into the urine. It is difficult to offer any alternate explanation of the presence of albumen, because there was no recurrence of albuminuria when fish was again taken; but there can be no doubt that it was in some way dependent on the particular form of diet.

To conclude, then, the attacks of tetany are due to a toxin absorbed from the digestion of fish, which process also causes a second body to be absorbed, which does not produce tetany, but is excreted as acetone and di-acetic acid.

Incidentally it may be mentioned that this was the first case in which the large nutrient enemata recommended by Dr. Beddard in the GAZETTE were tried. At a time when the patient could take scarcely any food by the mouth, these enemata were ordered every eight hours, to be given by a high rectal tube, with the hips well-elevated on a pillow for at least an hour after injection. The bowel was washed out once daily. They were continued without intermission for seventeen days and on only two occasions were they returned. They caused practically no discomfort and patient maintained her weight.

In Lighter Vein.

THE two great events of the week have been the Mansion House mass meeting and the farewell dinner to Mr. Pakes. Of the latter, the less said the better. The Mansion House function commenced at 3 o'clock, and punctually at that hour the notabilities began to arrive. First, a picked gang of Guy's men, in a four-horse charabanc, under the charge of Superintendent Gibson. As this party had only one top hat between them, it necessitated going in one by one, and having the hat passed out by the hall porter. The crowd in front of the Mansion House greeted them with the wildest enthusiasm.

At 3.5 Mr. Brydone alighted from a Moorgate Street 'bus, closely followed by the conductor. (The fare has since been paid.—ED.)

Dr. Galabin, arriving shortly after this, carrying a small black bag, was mistaken by the police for an anarchist, and hurried below to the cells, whence he was liberated only late in the afternoon.

The meeting was most impressive. The two things on the platform that attracted and held the eye spell-bound were the Lord Mayor's diamond badge and Mr. Bonsor's smile. The company on the platform consisted of Mr. Wells, the Lord Mayor, and others.

The Lord Mayor made an excellent and impressive speech, concisely stating the whole matter. This was clearly felt by the speakers that followed, for each prefaced his remarks by saying that there was nothing left for him to say.

Mr. Leopold Rothschild, in an excellent speech, said that on making an unofficial visit to Guy's he was struck by the appearance of the building; he was struck by the nursing home; he was struck by the lift; he was struck by the patients; he was struck by the intimate acquaintance Mr. Bonsor had with patients and nurses. (Applause). In spite of the rough treatment he received, Mr. Rothschild, as usual, showed himself to be a noble and generous gentleman by quietly giving a cool £1,000.

Amongst the audience we saw several of the junior staff, some sisters, Mr. Fremantle (busy selling copies of his book), Mr. Wacher (wearing a beautiful carbuncle), Colonel Lucas, and others.

On leaving we, like Mr. Rothschild, were struck by the pigeons, Mr. Hodgson in particular

THE BIRD OF PREY.

Nursing News.

MATRON'S OFFICE.

It is with much regret that we have to announce the death of Nurse C. Heygate (Head Nurse in Miriam ward), on Sunday, the 5th instant, from typhoid. Nurse Heygate entered the hospital as a probationer in October, 1898, and completed her three years' training on December 22nd, 1901. On Thursday, the 9th instant, previous to the body being taken to Woking Necropolis, a funeral service was held at 8.30 a.m., the coffin (which was covered with flowers, amongst them being a wreath and cross sent by the Nursing Staff) was conveyed to the Hospital Chapel, followed by as many members of the Nursing Staff as could be spared from the wards, the service being also attended by several other members of the Hospital Staff with whom she had come in contact. Nurse Heygate was greatly liked by all who knew her, and much sympathy is felt with her parents and relations in their sad bereavement. It has been decided by the Nursing Staff to place a memorial to her in the Mortuary Chapel.

Sister Emma (Miss Studdert) the Surgical Night Sister, has been appointed sister of Martha ward, and Miss Constance Mudge, who entered the hospital as a probationer in March, 1898, has been appointed Probationary Surgical Night Sister.

Miss Jessie Fraser Ballantyne, who left the hospital in August, 1897, and lately held the post of Assistant Matron at the Lewisham Infirmary, has been appointed Matron of the Southampton Workhouse Infirmary.

The following nurses left the hospital on the 1st instant, having completed their training. Nurse V. Wood, Head Nurse in Patience; Nurse Hembling, Head Nurse in Bright, and Nurse C. Allen, Head Nurse in Lydia. Nurse Spalding, Head Nurse in the Out-patient department has been appointed Head Hurse in Patience, and Probationer E. Crowe was appointed Head Nurse in the Out-patient department.

On the 4th instant, Nurse Harradine, left the hospita on completion of her training, to take up her duties on the Private Nursing Staff, and Probationer Savage was appointed to succeed her as Head Nurse in Naaman ward. Probationer A. Allen has also been appointed Head Nurse in Stephen ward.

On the 9th instant, Nurse Graham left the hospital, and Probationer Parr was appointed to succeed her as Head Nurse in Astley Cooper.

On the 10th instant, Nurse E. Creasey left the hospital, and Probationer Walter was appointed to succeed her as Head Nurse in Naaman ward. Probationer G. Field was also appointed Head Nurse in Miriam ward.

On the 11th instant, Nurse Blayney, Head Nurse in Patience, left the hospital to join the Private Nursing Staff. Nurse Minshall, Head Nurse in Philip, was transferred to Patience, and Probationer Hecks was appointed to succeed her as Head Nurse in Philip. Probationer Milman was also appointed Head Nurse in the Out-patient department.

Birth.

HARDING.—On December 31st, 1901, at Whittlesea, Cambridge, the wife of C. Headley Harding, M.R.C.S., L.R.C.P. Lond., of a daughter.

Death.

CARRINGTON. — On December 26th, 1901, at 8, Battersea Rise, S.W., William Henry Carrington, L.S.A., L.R.C.P., aged 45 years.

ED.—D. G. G.

Contents.

	PAGE
INCOMPLETE ABORTION: Clinical Lecture by Mr. Targett ...	45–49
SOME NOTES ON PARACENTESIS AND ACUPUNCTURE: by A. J. Cleveland	49–52
AN HISTORIC LETTER	52–53
TYPES	53–54
THE MODERN DRAGON OF WANTAGE OR THE WORRYING WORM	54
PASSIM	55–58
OBITUARY: Wordsworth Poole	58–59
THE DEBATING SOCIETY	60
IN LIGHTER VEIN	61
CORRESPONDENCE: South African Memorial	61
APPOINTMENTS	62
SPORT: Rugby Football—Guy's v. Old Leysians; Guy's v. Rosslyn Park; Guy's 2nd XV. v. Beckenham. Association Football—Guy's v. Old Eastbournians; Guy's v. Beckenham; Guy's v. Beckenham; Guy's v. Eastbourne; Inter-Hospital Cup Ties	62–64
CHAPEL NEWS	64
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	64

Calendar of Coming Events.

February, 1902.

Sat. 1.—Messrs. Jacobson and Fripp's take-in; Drs. J. Goss and L. H. Ackroyd; Cl., P. N. Blake-Odgers.
G.H.R.F.C., I., R.I.E.C., away.
II., Polytechnic, away.
G.H.A.F.C., I., Ewell, away.
II., Central Technical College, home.

Mon. 3.—1.15 p.m., Clinical lecture by Dr. Horrocks.

Wed. 5.—1.30 p.m., Clinical lecture by Mr. Jacobson.
G.H.R.F.C., II., R.I.E.C., II., away.
III., Dulwich Col. II., away.
G.H.A.F.C., II., St. Thomas' 2nd XI., away.

Thur. 6.—Messrs. Howse and Symonds' take-in; Drs. H. C. Winckworth and G. L. Buckeridge; Cl., J. Atkins.
G.H.C.U., Address by Colonel Macgregor.
Test Exams. for Revision Classes for Final L.D.S. Eng., begin.

Sat. 8.—1.15 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I., Kensington, home.
II., R.I.E.C., II., away.
G.H.A.F.C., I., Cheshunt, home.
II., Cheshunt 2nd XI., away.
Dental Society's Dinner at the Hotel Cecil.

Mon. 10.—1.15 p.m., Clinical lecture by Mr. Brailey.

Wed. 12.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., III., Merchant Taylors School, II., away.

Thur. 13.—Messrs. Lucas and Lane's take-in; Drs., J. T. Hicks and N. I. Spriggs; Cl., S. Hodgson.
G.H.C.U., Address by A. C. Tessier, Esq.

Fri. 14.—4 p.m., Meeting of the Dental Society.

Sat. 15.—1.15 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Lennox, away.
II., Lennox, II., home.
III., Old Alleynians, III., away.
G.H.A.F.C., II., City of London School, away.
G.H.P.P.S., Pathological Meeting.

Guy's Hospital Gazette.

FEBRUARY 1, 1902.

Incomplete Abortion.

CLINICAL LECTURE BY MR. TARGETT.

November 25th, 1901.

GENTLEMEN,—I shall make no apology for introducing such a common-place subject as Incomplete Abortion, because of its very great importance. There is no doubt that in general practice it is one of the most troublesome conditions one has to deal with, and I have heard many practitioners say from large experience that they would rather have to attend half-a-dozen normal labours than one abortion. This is chiefly because of the numerous complications which may attend a miscarriage. I have tabulated some of these complications, and we will refer to them in detail.

We have recently had two cases of septicæmia in Patience ward, both of which were the result of incomplete abortion. One unhappily died after a very short residence in the hospital; the other one was apparently saved by the timely use of antistreptococcal serum. Both cases were good examples of the complications which we get in abortion, and I propose to use them as illustrations of the subject before us.

The importance of abortion depends on its complications and sequelæ. The majority of patients are disposed to regard it as trivial, simply because they do not know any better; but we, looking at the matter from a pathological point of view, know very well that abortion is often the precursor of other diseases, which perhaps do not occur for weeks or months afterwards, and, therefore, are not attributed by the patient to the abortion. The importance of this subject may be estimated by comparing it with so grave a condition as strangulated hernia, and it must be attended to with quite as great promptness.

At the end of the third month of gestation, the placenta is formed, and the coverings of the fœtus are in apposition and probably adherent to the decidua. It is then more difficult for the

uterus to expel the ovum, and consequently when an abortion occurs at that period, something may be left behind, and what that is becomes a matter of very great importance.

There are several clinical varieties of incomplete abortion. Firstly, the fœtus alone may be expelled and the remainder of the ovum be intact; secondly, there may be partial retention of the placenta and decidua, or of the decidua only; and thirdly, there is a variety called placental polypus. A small piece of the placenta is left behind, and on its surface there gradually forms a thick cap of clot and fibrin. If not expelled, this polypus produces menorrhagia and subinvolution of the uterus. But the symptoms are nothing like so severe as in the second variety above mentioned, and they may come on weeks instead of days after the miscarriage.

Now I want to draw your attention to two cases where there was a partial retention of the placenta or membranes in the uterus.

Case 1.—This patient was a very stout woman, aged 40, who had had eight or nine children. She was suddenly taken with uterine hæmorrhage in the street and passed an enormous quantity of blood. A doctor saw her, and what was done I cannot say, but she was not seen again for some ten days or so. At that time her temperature was 103°, and she had a foul discharge; she had lost a good deal of blood in the interval as the result of repeated hæmorrhages. When I saw her in the ward I found her very ill and extremely anæmic from the amount of blood she had lost. On vaginal examination, a piece of placenta was lying in the os uteri, which was widely dilated. The uterus was at once evacuated under anæsthesia, and antiseptic douches used. As her temperature did not fall the following morning, we gave her some antistreptococcal serum, but it was of no avail. She had a history of diarrhœa on admission, which became uncontrollable, and death supervened on the fifth day after the operation.

Post-mortem, we found the diarrhœa was due to a condition of acute septic colitis. The septicæmia exhibited its effects chiefly in the region of the sigmoid flexure, and the case was practically hopeless from the first.

Case 2.—The other case was a woman of the same age, 40, and she was also a multipara. She had had eight children but no previous miscarriages. Both these patients were advancing in years, and at such an age pregnancies are more likely to end in abortion. This woman was suddenly taken ill on November 1st, when three months pregnant, with hæmorrhage and pain, and she passed some large clots. She was seen the same night and nothing unfavourable was reported as to her condition. Most of the ovum came away on the following morning. Her temperature went up and she was seen again on the following Tuesday, November 5th, or four days after hæmorrhage had occurred.

On admission, a simple vaginal examination revealed at once the presence of an incomplete abortion. Lying in the os, and projecting from it, was a mass of retained placenta. Her temperature was raised to about 100°, and her pulse rate was 115. We immediately cleared out the uterus under anæsthesia, but before doing so cultivations were taken from the interior of the uterus on sterilised swabs. On staining a smear of the discharge with methyl blue, organisms were found which had the characters of streptococci. The result was sufficiently definite to justify a trial of the antistreptococcal serum, and an injection was given at once. On the following morning the broth culture showed the presence of a pure growth of streptococci, so that the diagnosis was confirmed within twelve hours. It was then decided to continue the serum treatment. She had the usual two bottles (20 c.c.) to begin with, and on the following days she had 10 c.c. once or twice, depending on how the temperature went. From the chart you will see how much the temperature fell after each injection of serum.

So much for these two cases. They both showed the two most important complications of incomplete abortion—*hæmorrhage* and *sepsis*.

(*a*). As regards hæmorrhage, although the amount of blood lost at an abortion might be sufficient to prove fatal, it is very rare for that to happen. Yet in an indirect way it has a

very bad effect on the health of the woman. For months after an abortion I have seen women anæmic and dyspeptic, and quite unable to carry on their proper duties.

(*b.*) If the patient has lost a great deal of blood she is much more liable to get thrombosis. Whether this is due to the introduction of septic matter into the blood, in addition to the effects of the hæmorrhage, we need not enquire. But you all know how tedious a case of thrombosis in the legs may be; it is usually months and it may be a year before the patient is able to resume her ordinary duties.

(*c.*) Incomplete abortion may lead to sapræmia, that is to say, the substance retained becomes putrid and gives rise to a foul discharge. Unfortunately it is the custom of some practitioners to leave these cases alone until the discharge becomes foul. They give ergot in large quantities to control the hæmorrhage, but take no steps to discover whether the abortion is complete or not. A case ought never to be allowed to get into the putrefactive stage, for you do not know how much septic infection will accompany the sapræmia. It is like waiting for a hernia to become strangulated, before putting on a truss.

(*d.*) Sepsis is a much more severe complication than sapræmia, and therefore it is of still greater importance. When sepsis is introduced into the patient either through the putrefactive changes going on in the retained placenta, or from dirty hands and instruments, then she will develop septicæmia in one or other of its varieties. In both of our cases there was this condition, and if we had seen the first patient before there was so much evidence of general infection, it is not unlikely that the serum would have done as much good as in the second case. Case 1 was not admitted until fourteen days after abortion, the other on the fourth day.

(*e.*) Besides sepsis we have other complications which are often forgotten, for the simple reason that they do not stand in such close relationship to the abortion as those already mentioned. For instance, endometritis may give rise to menorrhagia and eventually be followed by salpingitis. In cases of salpingitis, always search for sepsis or something kindred as the cause; and sepsis is much more common after abortion than labour at term.

(*f.*) Last, but by no means least, is the condition of subinvolution which follows abortion. The uterus does not properly involute or shrink back to its original size, simply because there is a state of chronic inflammation in its inner and middle coats. Then if the uterus is too large and its walls are lax, retroversion is a common result.

Let us now turn to the clinical aspect of this subject and consider the diagnosis. When called to a case like this, how will you make a diagnosis? It is not in every case by any means that on vaginal examination you will feel a projecting mass. If that were so, the diagnosis could be dismissed in a moment. But it is not so. You may be told that the patient was taken with severe pains, had profuse hæmorrhage, and then something came away. Women have unfortunately a habit of doing away with what has passed as quickly as possible. So that an opportunity of examining it is very rarely given us. If the patient is wiser, or if the nurse understands her work, she will have kept it for the doctor to examine. In looking through the clots, if you find the fœtus but no portion of the placenta, that is a valuable point in the diagnosis; for what is left behind will be the whole or greater part of the placenta and membranes.

When you come to examine the patient, what are the signs that the uterus is empty?

(1.) Firstly, it is diminished in size. Enquire carefully into the history of the gestation and compare its present size with what is proper at that period of pregnancy.

(2.) Secondly, its shape is quite altered. The uterus is flattened from before backwards, whereas the pregnant uterus presents itself as a uniform globular swelling. But if the liquor amnii has escaped, and the fœtus with it, then the uterus becomes altered in shape, and the more so as the greater part of its contents have become expelled. Therefore take the flattened shape which it assumes when empty as a sign of its being empty. Immediately after labour the anterior and posterior walls come into close

apposition, and there is a flattening of the uterus from before backwards.

(3.) Thirdly, the uterus is more likely to be irregular in outline; not soft or elastic, but harder here and there, the harder spots corresponding with the masses of placenta, as though there were small fibroids in the wall.

(4.) The next most marked feature is the condition of the internal os. We cannot form any conclusion from the state of the external os, because it may be lacerated and patulous from previous confinements. But the internal os is not affected in that way. If the uterus is empty the internal os closes within a few hours of labour; and forty-eight hours after a complete abortion you would have great difficuly in getting your finger through the internal os. That being so, the condition of the internal os is of great importance. Supposing there is something retained in the uterus, we expect to find the internal os either patent, or so soft that it can be easily dilated with the finger.

(5.) On digital examination of the uterus the placental site should be quite smooth, or very nearly so, in a case of complete abortion at the end of the third month. If the abortion has taken place in the fourth or fifth month, the placental site will be somewhat thicker and rougher than any other part of the wall.

(6) If the uterus has expelled its contents, the lochial discharge is similar to that which occurs after a full-term delivery. But after two or three days the amount of discharge in a case of complete abortion is very scanty. Hence, if it is considerable you should ask yourself at once whether there is anything which prevents the uterus from contracting down. Of the importance of a foul discharge we have already spoken.

If from the absence of the foregoing signs we consider it to be a case of incomplete abortion, what will be the line of treatment? First of all a vaginal examination is imperative. You must make a vaginal examination in order to complete your diagnosis. That would seem quite obvious so far as our own treatment of hospital cases is concerned. But in general practice you meet with patients who are foolish enough to think that there is no necessity for it, and that a miscarriage is a very simple matter. But in the interest of the patient you should insist upon a vaginal examination, and then you ought to be able to decide whether the abortion is complete or not. I do not say that you can in this way diagnose every case in which there is a little bit left behind such as might eventually form a placental polypus. You might have your suspicions even then, though more probably it would be overlooked.

Having once made your diagnosis that the abortion is incomplete, there can be no doubt as to what must be done. The operation must not be put off till to-morrow or the next day in order to suit some domestic convenience. The uterus must be cleared out at once, for the operation is just as imperative as in a case of strangulated hernia. You do not know what amount of septic infection may take place if she is left for another twelve hours.

Now comes a question that in practice stands often between the medical man and the proper performance of his duties, and that is, the necessity of an anæsthetic. You have to anticipate this difficulty. Tell the patient that you have strong reasons for believing that there is something left behind, and that it is very important that this should be removed at once. Although the operation can be done without an anæsthetic, yet it is much more thoroughly and rapidly performed under anæsthesia. So that I advise you to give an anæsthetic. I have done operations of this kind without it, but I never feel so satisfied with the results. The object of the anæsthetic is to relax the abdominal wall so that you may be able to grasp and depress the uterus in carrying on the necessary manipulations.

The use of the sharp curette in this operation should be avoided as a rule. It will sometimes do what your finger cannot do; on the other hand, it may do a great deal more than you wish. With the finger you can feel what you are doing. There is one advantage in the curette. It can be sterilised but you cannot be so sure of sterilising your finger; this knowledge should make you all the more careful to take proper antiseptic precautions. The flushing curette or spoon is very useful for washing

out the interior of the uterus, but for removing adherent membrane or placenta the finger is far and away the best instrument.

Usually it is best to put the patient in the lithotomy position, but if the operation is being done without an anæsthetic, she should be placed in the obstetric position. You can then draw back the posterior vaginal wall with a Sims' speculum, and pull down the uterus with a tenaculum. As regards other details, it is quite necessary to shave the vulva, because a good deal of blood clot adheres to the hair, and cannot be easily removed. Then give a vaginal douche so as to wash away all clots and discharge in the vagina. For that purpose do not use perchloride lotion or formalin, because they narrow the vaginal passage. Lysol lotion is best. Next you must work one or two fingers of your right hand gradually into the uterus, and support the fundus with your left hand. If the patient is well under an anæsthetic the fundus of the uterus can be pushed down upon the internal fingers; and thus the top of the uterus can be thoroughly explored. After the fragments are detached, if you have been able to get only one finger into the uterus, frequently you cannot withdraw them. Therefore press on the fundus and try to express them. If that fails the uterine forceps can be slipped in, and with them the fragments are withdrawn. Go over the whole of the interior of the uterus, particularly the two cornua, and when you have detached several fragments give an intrauterine douche of lysol. Then pass your finger back again and feel whether there are any other adherent fragments. If so, detach them and repeat the douche. Make sure, once and for all, that the uterus is thoroughly emptied, and the remainder of the operation is simple. You should finish up with an intrauterine douche of perchloride (1 in 2000), which can be followed with formalin lotion or boiled water. I have not seen any ill effects produced by perchloride used alone, but it is perhaps as well not to leave any inside the uterine cavity, and what you fail to express with your hand may be washed out with water. It is a useful thing for the first twenty-four hours to leave an iodoform gauze drain in the uterus—not as a plug to stop hæmorrhage, for the uterus contracts down very quickly—but that all the oozing and discharge after the operation may drain away. Take a long strip of iodoform gauze and carry it with the sound to the top of the uterus. Remove it at the end of twenty-four hours, and give a vaginal douche. The drain need not be replaced.

Now as to the after-treatment. Once the operation is over, do not forget that the patient must rest just as much, perhaps ever more, than after a normal labour. She certainly ought to remain in bed for ten days, and longer if the case has been a bad one. It is wise also to give ergot during the convalescence. Concerning food, she should be given a nourishing liquid diet, to make up for the loss of blood. If there has been any retroversion preceding the abortion, and you find on examination that the uterus is now retroverted, it is worth while to insert a Hodge's pessary, so that the uterus may involute in a better position. Perhaps the retroversion may be cured in this way.

Some Notes on Paracentesis and Acupuncture.

By Dr. A. J. Cleveland.

The words paracentesis and acupuncture must be so familiar to all who have done much ward work that an article on the subject seems to me to need some justification. As a matter of fact, familiar as are the words the operation, as such, is barely described in the commonly used text-books. General indications are given as to its necessity, but full details as to actual performance can seldom be found.

In the following article some attempt has been made to discuss the conditions indicating the necessity for paracentesis and acupuncture, and the necessary details of method, with some of the possible untoward results.

Paracentesis abdominis. — The usual indications for this are—

1. Increasing pain and distress from the distension of the abdomen.

2. Impaired action of heart or lungs from the pressure of the fluid.

I will not enter into the question of the diagnosis of ascites; it is usually easy, though not always so, but before tapping care should be taken to find out whether the signs indicate that fluid is present beneath the seat

of puncture, as tumours or enlarged viscera must of course be carefully avoided.

The usual site for the puncture is in the middle line, about half-way between the umbilicus and the pubes, but for various reasons this may not be suitable.

Thus, if the fluid be due to malignant peritonitis there may be a mass of growth in this region, arising possibly from bladder or uterus, or the skin here may be inflamed, or there may be the wound of a previous laparotomy which it is not advisable to reopen, or perhaps the position or comfort of the patient makes some other spot desirable.

In such an event the best place to choose is some two or three inches above the middle of Poupart's ligament, taking care to remember the line of the deep epigastric artery. In some cases neither of these sites is eligible, and it may be necessary to drain from the side, towards the flank, about half-way between the iliac crest and the costal margin. Two difficulties arise if this spot is selected; firstly, in a fat patient the abdominal wall is often of greater thickness in this situation than the Southey's tube is long, and, secondly, the trochar may be inserted too far back, and the peritoneal cavity missed. The former difficulty is not very uncommon and it may be necessary to employ a fine canula such as is used for chest aspiration.

The instrument which is now almost universally used is a Southey's tube. By this the fluid is gradually withdrawn and the syncope which often followed the sudden disturbance of intra-abdominal pressure after a rapid removal of fluid, as in the old method with a larger trochar and canula, is avoided. Another great advantage of a Southey's tube is that it is clean; there is no danger of the fluid pouring all over patient and bed, and the objection that its slowness allows fluid to re-accumulate as fast as it is withdrawn is hardly borne out by experience. The apparatus consists of a trochar which fits a set of tubes of different sizes with small lateral holes. Each tube or canula has a top which screws on and off allowing a flat metal disc or guard to be attached to it, which can be fixed to the abdominal wall by strapping and the tube thus kept in place whilst the fluid is being drawn off. A long piece of indiarubber tubing joined to the screw top of the cannula leads into a vessel placed by the side of the bed.

This tubing is the cause of the first difficulty. It is extremely awkward to affix it to the Southey's tube after withdrawal of the trochar, when the ascitic fluid, generally very greasy, has started running out.

The usual plan is to first attach the tubing to the canula then run the trochar through one wall of the indiarubber tubing and down it into the canula. Then make the puncture. The great objection to this method is that a hole which is liable to leak is generally left in the tubing after removal of the trochar. The best way is to remove the screw top of the canula and attach it to the tubing. Fit on the guard and pass the trochar down the canula, make the puncture, remove the trochar and rapidly screw on the top with the tubing attached to it. Then fix the guard to the abdominal wall with two pieces of strapping. This method is quite simple, and can be done quickly without any leakage.

The dangers of paracentesis abdominis are not many. Of course the operation, unless done with the strictest aseptic precautions is highly risky. These patients have, as a rule, little resisting power; the abdominal wall is often œdematous, and all the conditions are favourable for the growth of any organism which may be introduced.

On the other hand, the use of strong antiseptics is to be avoided, at any rate to a great extent. Vigorous scrubbing of the skin and the liberal application of 1 in 20 carbolic lotion may be quite sufficient to cause a troublesome sore, which heals with difficulty and may result in extensive sloughing.

Veins should be avoided. These are generally rendered quite obvious by the pressure of the fluid on the deep veins causing the superficial ones to enlarge in order to carry on a collateral circulation.

The *deep epigastric artery* or the *bladder* are liable to be punctured. Before doing paracentesis abdominis, always see that this latter organ is empty.

The *intestines* always seem to get out of the way. I have never heard of them being injured in a simple ascites, but if adhesions are present they may be damaged.

Faintness may occur during the operation, and some stimulant should be handy in case of need. If the faintness persists and is serious, the withdrawal of the fluid should be stopped, but this rarely becomes necessary. The tube should be left in for about six hours, unless it stops running before that, but there is no objection to leaving it in longer if there is plenty of fluid to come away. In the event of its being blocked, the top can be unscrewed and the cannula cleared with a fine probe. As the abdominal wall becomes lax, the tube tends to slip out, and may require attention, and it is advisable to have a binder round the abdomen, which can be tightened when necessary. After removal of the tube, apply a sealed dressing and a firm abdominal bandage.

It sometimes happens that a patient with chronic peritonitis and ascites develops suddenly an acute peritonitis, and although this may be directly due to a septic instrument, it may occur quite independently, and no blame need be attached to the operator.

Paracentesis thoracis is an operation which used to be attended with enormous risk, and the great advance of surgery from the application of aseptic principles is illustrated in no better way than by considering the consequences of this procedure before and since the days of Listerism.

Stephen Paget, in his "Surgery of the Chest," quotes several cases of what used to be. Here is one:—

"A man aged 40 was admitted to hospital in 1877, on the seventh day of an acute pleurisy. During the next eleven weeks he was punctured fifteen times, and a total of sixteen pints of fluid drawn off. After the fifth puncture the previously serous effusion became purulent;

at the fourteenth it was putrid and mixed with gas. An incision was eventually made and the cavity washed out, but the apparent recovery ended in death from lardaceous disease."

This is but one of many illustrations of how fatal carelessness in asepsis may prove to be.

The diagnosis of fluid in the chest presents many difficulties, and aspiration should never be tried until the exploring needle has revealed the presence of fluid. Care should be taken to insert the trochar into the exact spot of the puncture of the needle, as it is so easy to miss fluid in the chest, even when present in great quantities, and needless pain is given to the patient if, through neglect of this precaution, it should become necessary to make two or more punctures.

Paracentesis of the chest is nearly always done for the removal of fluid, but sometimes a pneumothorax is treated in this way. The indications for removing fluid from the pleural cavity are briefly:—

1. Great distress, cyanosis or feeble heart action.

2. A large amount of fluid; say extending as high as the fourth rib. Such an effusion, if left, may cause sudden death.

3. Considerable displacement of the heart. Here, again, there is a risk of a fatal syncope from interference with the action of the organ, or from kinking of the big vessels.

4. Persistence of fluid after a reasonable time has been given for it to absorb (most authorities allow three weeks). Naturally as regards this indication each case must be judged on its own merits. The danger of leaving a lung for long compressed by fluid is that it may become permanently collapsed and fibroid.

5. In pleurisy with effusion the attendant pyrexia with quick pulse, etc., may sometimes be relieved by drawing off the fluid.

6. If the effusion is purulent. It rarely becomes advisable to leave an empyema alone.

As to the methods employed, the usual is by *Potain's aspirator*, in which the fluid is sucked into bottles previously exhausted of air.

Dieulafoy's instrument consists of a syringe with a two-way tap. By this the interior of the syringe is first connected with a hollow needle in the chest, and the fluid drawn off by pulling out the piston, then the tap turned and the piston pushed down, so that the fluid is expelled into a vessel. Although I have no practical experience of this instrument, it seems to me to have many theoretical advantages over Potain's, but the latter is the one in general use.

A *Southey's tube* may be inserted and left to drain as in paracentesis abdominis; this is not always successful, though the slow removal of the fluid by this means avoids some of the dangers to be mentioned later. Sometimes the fluid is under sufficient pressure for it to flow out through a cannula inserted with a trochar in the ordinary way, especially if the patient aids by coughing. However, this method is much inferior to that of the aspirator. Incision and drainage, often with resection of a piece of rib, is the familiar method of treating empyemata, and serous effusions are sometimes similarly treated when aspiration is unavailing.

The mechanism of the aspirator is quite simple and an examination of the instrument will explain it more than many words. Before starting the operation see that everything is in working order. This may seem too obvious to be worth mentioning, but I have often known faulty tubing or a tap that refuses to be turned only discovered after the puncture had been made.

The seat of election for inserting the needle is the eighth space, in a line with the angle of the scapula, or a little outside (Clifford Allbutt).

Cocaine, or the ethyl chloride spray may be used to deaden the pain of the stab, though many patients bear it quite well. Having carefully sterilised the instrument and washed the skin, feel for the intercostal space with the forefinger of the left hand, make the puncture rapidly, withdraw the trochar and turn the tap which admitted it, so as to shut off the outside air from the pleural cavity. Then open the tap leading to the exhausted bottle and allow the fluid to run out. The trochar should not be inserted too deeply. The patient is generally made to sit up in bed during the operation, a position which is often tiring, and it is better in some cases, even if not quite so convenient, to prop him up with the side to be aspirated near the edge of the bed, so that it can be easily got at.

If the fluid stops running and there is reason to suppose that plenty is still present, first ascertain that the bottle is properly exhausted and that there is no leakage of air, and then see if the needle has got blocked, in which case it should be cleared with the blunt pilot.

Supposing neither of these causes be found, gently alter the direction of the cannula, moving it from side to side, upwards or downwards, and then slowly withdraw it a short distance, in order, if possible, to find the fluid. If this fails try a fresh puncture; the fluid may be encysted and you may only have tapped a small collection.

It is a mistake to draw off the fluid too rapidly, and if the effusion is a large one this is particularly to be guarded against, as the sudden alterations of intra-thoracic pressure may have alarming and often fatal effects on the heart and lungs.

When the fluid ceases to run, or when sufficient fluid has been removed, the canula should be withdrawn and the puncture sealed with a collodion dressing.

The indications for stopping aspiration sooner are—

1. Faintness.

2. Feeble and rapid heart's action.

3. Cough, especially when accompanied by hæmoptysis.

Faintness and cardiac failure are generally due to the altered conditions in the chest caused by the removal of fluid, and the cough and hæmoptysis are probably caused in the same manner, and are not due to direct wounding of lung or pleura, though this accident is quite a possible one.

The dangers and complications of paracentesis thoracis, in addition to the three just mentioned, are—

1. Serous œdema of the lung with profuse albuminous sputa. This rare but terrible complication is caused by a rapid withdrawal of fluid, and a sudden swamping of the expanding lung by transudation of serous fluid into its substance (Stephen Paget). The patient becomes very dyspnœic and expectorates profusely a clear frothy erous fluid which often chokes him. This accident cannot be foreseen, but in a patient in whom it has once occurred it may be subsequently avoided by slow removal of the fluid, as with a Southey's tube.

2. Puncture of lung, heart or diaphragm ought to be avoided with ordinary care, but even skilful men have made the mistake.

3. Introduction of septic matter. This is inexcusable nowadays.

4. Infection of the tract of the puncture, where the fluid removed is septic. This is not common.

5. Striking a rib with a trochar is a not unlikely accident when the intercostal spaces are small, but a little care generally enables one to avoid it.

6. Wounding the intercostal artery can be avoided by keeping near the upper border of the rib.

7. Air may be admitted, and a pneumohydrothorax be formed. Air can get into the pleural cavity either from the lung or the outside. In the former case the lung is generally weakened by tuberculous disease, growth or gangrene, and on expansion gives way, an accident not likely to be avoided even if foreseen. In the latter, carelessness or a leaking aspirator may allow it to enter.

Paracentesis pericardii can be done either with an aspirator, an ordinary trochar and canula, or by incision. The latter method is best for a pyopericardium.

The great difficulty arises in diagnosing the condition correctly. The physical signs and symptoms may be very fallacious, and the heart has often been wounded owing to a dilated heart being mistaken for a pericardium distended with fluid. If much fluid is present, puncture in the fifth left space about half an inch from the sternum will generally enable it to be withdrawn, but it must be remembered that the fluid tends to gravitate towards the back; the heart may be fixed in front by adhesions, and no good be done by puncture even in several places, whilst if the ventricle be wounded, a fatal hæmopericardium may result. Still, where there is much fluid its removal is often simple and brings great relief.

Acupuncture. In many cases of cardiac and renal diseases fluid accumulates to such an extent in the thighs, scrotum and legs, that it is necessary to remove it, not only on account of its discomfort, but because of the danger of the tissues sloughing.

The two methods in common use for this purpose are puncture in many places with a needle and the insertion of a Southey's tube. The latter method is not advisable, as it has scarcely any advantages over acupuncture, and is far more liable to cause damage to the tissues and a slough results, rapidly followed by extensiv cellulitis. In the one case in which I have seen a Southey's tube used in the leg, this was the order of events, the patient dying quickly.

Asepsis is imperative, so not only should the skin, instruments and hands be rendered as aseptic as possible, but care must be taken to avoid subsequent contamination. The scrotum sometimes requires puncture, and especial care must be taken to guard against the many sources of infection in this part.

After the legs have been cleaned (soap and water and a weak solution of lysol are sufficient), it is best to smear them over with a thin layer of aseptic or mild antiseptic ointment. Unguentum Acidi Borici answers well, though I doubt either its antiseptic or aseptic properties. There are two advantages in doing this. One is that the fluid is prevented from making the skin sodden and consequently sore, and the other that it is a protective against infection.

Take a large needle, preferably triangular in cross section, and rapidly make some six or eight punctures about one to two inches deep in different parts of the limb through the ointment. Then wrap round with some absorbent and aseptic wool, and allow the legs to be dependent, or sit the patient in a chair. A lot of fluid can thus be got rid of, and great relief given.

Be careful not to stab too deeply; it is rare to even draw blood, and the only danger I know of is that the punctures may become septic.

An Historic Letter.

DOCTOR AMIAN'S PRACTISE OF THE INOCULATION, 1723.

SIR,—This is to inform you of the particular manner of taking, receiving, conveying and ingrafting the *Purulem* Matter of the Small Pox, in order to bring forth that diſtemper *artificially*.

All this requires ſo very little ſkill, that in *Turkey*, the old women are the Perſons imployed for thoſe *Operations;* There and here, we open the *Pustulas* of the distinct Small Pox, from and after the time they begin to turn and go off in the Face untill they are almost dryed off; Nay we ſometimes *inoculate* the ſcales themſelves.

Theſe *Pustulas* may be opened with a flatt needle, pin, or Lancett, and the Matter flowing or preſſed out, I take up with lint, and put up in a flint glaſs, cloſely ſtopped up, and ſo keep in warm till I can *inoculate* it; I never keep it above 4 or 5 hours, ſome have kept it longer before they have applyed it, without any material difference. Some require that the matter should be collected by one, and applyed by another; I have generally done both, and I have never obſerved that thoſe in which the *Operation* was made, appeared to have received by *infection* any taint of the diſtemper.

The Small Pox procured by *inoculation* never appears till after the 7th day of the *inoculation*, very ſeldom upon

the 7th ſometimes upon the 8th but generally between the 9th and 10th tho ſometimes not till the 11th. We have two instances, one that is recorded and another that is not, wherein the Matter inoculated has layd brewing, in one during three weeks and half, and in another during eleven weeks; This was manifested becauſe the flushings, gentle head ache, want of appetite, and ſuch other accidents (as are previous to the irruption of the small pox *inoculated* and go off after the irruption) did continue on theſe two instances, untill the distemper did appear; if the distemper does not appear by the 11th theſe ſimptoms generally go off and the inoculated places heal up.

Generally ſpeaking the inoculated places keep open till the irruption of the Small Pox, Nay about that time they feſter and ſpread deep and wide, and then look fowle, Yet it ſometimes alſo happens that the inciſions heal up, before the 7th of the *inoculation* and break out again at the time of *irruption*, and I have known ſome in which they have never opened again, and the distemper hath been as fine as in thoſe in which the diſcharge through the *inciſions* was very great; This diſcharge is chiefly about the 7th of the small pox; then the pustulas generally turn and grow dry from the day of the irruption to that time. I dreſs the inciſion with digestive before the *irruption* with a Common Plaister to keep the *inciſion* moist, and at the Cloſe when the *inciſions* are clean, I dreſs them with dry lint, or any thing elſe neceſsary to keep the fleſh firm and in a healing ſtate.

Aſ to the *Operation* I generally perform it upon the two arms, the places I chuſe is that where the iſsues are generally made, and if there are iſsues made there, then I do it in ſome brawny part near it. The least *inciſions* are ſufficient, the large ones are attended with no inconveniencyſ. Thoſe I make are about the length of a barley corn.

I mark the length of the *inciſion*, and then pinching that part of the skin, paſs my lancet thro the part thus marked; My Thumb covers the *orifice*, whilst My ſervant gives me or I take the plaister, on the middle of which I have lodged a bitt of the imbibed or impregnated lint which I ſecure upon the inciſed part by a little bolster and filter. This is left on 24 hours and then removed. from that time to that of the Small Pox being intirely out, I order the inciſed parts, if raw, to be dreſsed daily with a common plaister, to keep them moist.

The Small Pox procured by this method, is of the distinct favourable kind, ſuch as need no other *Medicines* or *Phiſitian*, in being to go off upon the 7th day, and ſeldom or never pitts. Some have 20, others 100, generally 150, or 200, ſometimes more than can be counted.

I finde all preparations previous to the *inoculation* needleſs; after it the patient is forbidden all fleſh meats, He lives upon Pudding, gruel, and ſuch light food, and eats but half as much as he uſed to do, and he is kept from cordials, in a cool regimen, and gets up if He pleaſes all day long.

This practiſe has gained much Credit. I have *inoculated* 27, or 28 this ſpring, and I am Convinced no diſcovery in the way of *Physick* can tend more to the well fare of mankind than the *inoculation* of the Small Pox does; Doctor Jurin's compariſon of the mortality by the Small pox in the natural way, and by *inoculation* (published not long ſince) has perſuaded many. The incredulity can't ſubsist long! Truth will prevail! Every Body here is almost mad upon this account: I am for it, and I thinck I have the ſtrongest evidence.

Types.

No. 3.—A Cultured Man.

"Ned is indeed a true English reader, incapable of reliſhing the great and masterly strokes of this art; but wonderfully pleased with the little Gothic ornaments of epigrammatical conceits, turns, points and quibbles, which are so frequent in the most admired."—*Addison.*

Being an intimate friend, I kicked his door and without waiting for an invitation walked in and dropped into a chair of scholarly proportions.

He was out.

It was a restful scene that met my eyes. The walls, of a neutral colour, pleasing to the eye if objectionable to the nose in their linseed newness; no vulgar wallpaper to flaunt its flaming discord on an æsthetic calm. Pictures, there were a few, but not as you or I would choose them; dainty autotypes and rare old Bartolozzi prints in high art frames; nothing vulgar, no examples of that celebrated artist Cynicus, not even a "firm" group. Here, there, everywhere, scattered in studied negligence, were a few of the year's novels in Morris covers. In the easy chair lay an open volume of a minor poet. I sat on it. In the hanging bookcase a complete edition of Ruskin—uncut.

A gentle footfall; the door opens slowly and a tall, willowy figure is silhouetted against the wall of the corridor. His studied entry is marred by his tripping over a Nuttall's dictionary and a hasty reference to the gods. One review glares aggressively from a coat pocket, and his eyes are glued to another. A smile spreads slowly over his delicately-chiselled features, his lips part in ecstacy and he ascends heavenwards on the flight of his imagination. His look lights on me and he comes down flop to earth and earthly things.

"Ah, have you seen this week's Academy? Just listen to this."

A few sentences or so, accompanied by a graceful wave of the hand and then a quick, questioning glance at my unmoved face. A look of pain, not unmingled with pity for me so hopelessly commonplace, succeeds the enraptured expression, and then his words and tone seem to remind me of another. "Perhaps you don't quite see that. I'll read it again."

"Stop a bit; let me do a little talking. This is an interview, you know."

"Yes," he said, with a smile but a little paler than usual.

"Do you, ah, contribute much to the weekly journals?" I enquired with a suitable reverence.

"I usually pen a few articles," he replied, carelessly.

"Which are always returned——"

"Oh, no," he interrupted quickly, "one of my essays was not returned." Then dreamily, "I forgot to enclose a stamp."

"Do you approve of modern authors?" was my next attempt.

"My dear fellow," condescendingly, "I adore Meredith. The Egiost is so true to life."

I looked at him fixedly.

"I think you're right," I said.

There was an awkward pause. Then with great thankfulness I heard my name bellowed in the court-yard, and escaped with a hurried "Excuse me, I'm wanted."

PLAIN CARD.

The Modern Dragon of Wantage

OR

The Worrying Worm.

"Shure! and 'twas a notable wurrum." (Irish legends).

Deep in the darksome pelvic cave
By Iliac's ruddy stream,
A gay Appendix curled him up,
And thus began to dream.

He dreamt—or thought he did, the rogue!
That he was wondrous wise,
And, heedless of the cæcum near,
Did thus soliloquize,

Why should I idly spend my life
Clinging to this plump cæcum
Who gurgles, rolls and peristalts,
Calls me his "vade mecum,"

Nicknames me "Vestige"—with a sneer,
A "remnant"—like a sale!
I'll "sacrifice" and "remnant" him,
I'll teach him I'm his tail—

I'm sick of his eternal plaints
That I his movements clog,
It's about time the old fool learnt
The tail *can* wag the dog!

I'll simulate nephritic stone,
Acute uretral colic;
Ending with umbilical pain
My hæmaturic frolic—

So up the Appendix got and swelled
Like frog in classic fable;
Quickly to bed his host he sent
Swearing for all he was able—

The colon now began to feel
His own life not quite happy;
His peristaltic action failed,
Sluggish he grew and snappy.

The Surgeon came with solemn mien
And felt the patient's belly,
Who unresisting lay and smiled
Limp as a calves' foot jelly.

A day of reckoning followed soon
To the Appendix' great surprise;
For when he rose at 9 a.m.
A light streamed in his eyes

And through a ghastly, gory rent
In the host's belly wall,
He saw two fingers and a knife!
He gave one feeble squall.

He cut him from the cæcum's side,
And into spirit dropped him;
The nurse, however, custom-dried,
Into the fire popped him.

The wound—aseptic—quickly healed,
And the peristaltic action
Of the poor Colon, normal came,
To the patient's satisfaction.

He blesses, too, with all his heart
His Surgeon and his nurses,
And spends his time in finding words
To scathe that worm with curses

Passim.

"Fevrier que donne neige
Bel été nous pleige."

Mr. Richards' paper on "Medical Heresies," at the meeting of the Physical Society last Wednesday, was certainly one of the best we have heard read before this body. Written throughout in a keenly appreciative sense of humour, it was vastly entertaining and surprisingly interesting. Homœpathy and Christian Science are apt to appeal to our risible faculties from our very ignorance of their aims and scope. Mr. Richards, however, succeeded in giving a fair and judicial estimation of their value which lost nothing by its delicacy of humour. Some of his epigrams—the paper in *extenso* will be published later—are particularly happy. Of the Homœpathists, "Their experiments were inaccurate . . . . their main idea was unsound, their writings were as windy as their medicines were watery." And in giving a *résumé* of Mrs. Eddy's extraordinary work on Science and Health, "She spends two-thirds of a page in defining Mind. Her definition contains no less than thirty-eight abstract nouns, and no verbs at all." Again, "It is true that there are people who realize all Mrs. Eddy's dreams, people who feel themselves perpetually young, strong, beautiful and wise, under the most discouraging objective conditions. We have all of us been introduced to them by Dr. Savage—at Bethlem Royal Hospital. It is possible that she is right when she says that a continued study of her book would bring us all to that condition."

It was only natural that after this display of epigrammatic psychology, Mr. Fremantle should call attention to the "Importance of being Earnest" and work in a few remarks on things in general and the war in particular. Mr. Wacher also found the opportunity of exercising a little alliterative buffoonery too alluring to be resisted.

Last week's *Outlook* contained an appreciation of Wordsworth Poole as one of "the venturesome young men to whom the Empire owes much." The article strikes such a true note, fully realising the man's worth that we plead no excuse for quoting the following personal description. "Brilliant and brave and kind, particularly attractive both in manner and appearance, with fresh, fair complexion and blue eyes of that rare child-like blue so seldom seen in adults, Wordsworth Poole's personality, physical and mental, was full of charm and distinction. For him, as for so many in these last sad years, 'the day's high work is over and done'—but England is not unmindful of her sons who leave such a heritage of splendid memory."

The Out-Patient Department loses much by the retirement of Mr. Symonds, who has given up charge of the Throat Department, but we feel sure that no one is better fitted to fill his place than Mr. Steward, who has been elected as surgeon in his place.

With the advent of February yet another change in the staff of the hospital takes place. Dr. Cleveland resigns his office as Medical Registrar. The step he has taken means a distinct loss to the hospital. As House Physician and President of Residents his genial manner and kindly humour made him a most popular man in our midst. His election to the responsible post of Medical Registrar pleased everyone, and most ably has he filled the position. Now that he leaves us we cannot but render him the thanks of all here and wish him every success in his future career. Mr. French, who succeeds him, is well known to everyone, and he cannot fail to do both himself and the hospital credit in his new office.

Whether the Debating Society expected our Monarchy to totter to its fall as a result of their efforts on Saturday week we cannot say, but the meeting was certainly one of the most successful for many a long day. Not only did the subject of debate afford ample opportunity for the display of patriotism and the lack thereof, but additional interest was lent from the fact that the Chairman, who has done so much for the

Society since its birth, was present for the last time prior to his departure for South Africa. His farewell speech will long be remembered by those who listened to it, for he touched just the right chords for such an occasion. We all felt that in losing Mr. Pakes the Debating Society was being deprived of one of its strongest pillars of support.

THE question asked in another column by our valued correspondent, Mr. Stanley Hodgson, regarding the South African Memorial Fund, is a natural one. The answer is that at a meeting of the Gazette Committee held in July of last year it was, for reasons which will be obvious, resolved that the further consideration of the Memorial be postponed until the conclusion of warlike operations. At the time of writing it is hoped that the event is near at hand, and as soon as it comes to pass the project will at once be proceeded with. In view of the limited amount subscribed or promised, about £140 in all, whatever scheme is adopted must be a modest one.

GUY'S men are still in considerable numbers in South Africa and others are on the way. Mr. Maclachlan left by the Bavarian a fortnight ago, and to-day Mr. Pakes sails to take up his appointment as Bacteriologist and Analyst to the Transvaal Colony. To both of them we wish the best of luck and a safe voyage.

ALTHOUGH at present it is only rumour, we fear the evidence is only too strong that Malim, who many of the present time men will remember, is missing—probably killed in the Orange River Colony. Although only a comparatively short time at the hospital he became extremely popular with all those that knew him, and played both in the second eleven and afterwards took up the Rugby game. He enlisted in the 62nd Company of Yeomanry, and after a good deal of service was back in England last year. He went out again, obtaining his commission, and a letter from Sheffield, another Guy's man, states that Malim has been missing since an engagement on Christmas Eve, and grave doubts are entertained as to his safety. It is very distressing news to many of us and we can but trust that it will prove unfounded.

RUNAWAY victories are quite the order of the day with our present First Fifteen, and the match against Rosslyn Park was no exception to the rule. Earlier in the season they had defeated us by the narrowest of margins on their own ground, but at Honor Oak Park we took an ample revenge, running up the big score of 2 goals and 5 tries, 25 points to nil. The election committee had a difficult task in choosing the three-quarter line. Alcock has ably proved his claim to a place, and gave further evidence of his ability during the game. McEvedy was chosen to the exclusion of Orpen, who appeared in our opponents' rank. Our men played well throughout, and the halves opened the game up and gave the three-quarters plenty of opportunity of showing their powers, which they did to great advantage. Alcock played a great game, and his vigorous attack was quite the feature of the game, he scoring 4 tries. McEvedy, although not so good as in his old position, nevertheless played really well.

As no less than seven of our men played in the Surrey v. Kent match at Croydon, on Wednesday, January 22nd, there was, of course, considerable interest taken in the match by men in the hospital, and a fair number went down as spectators. Although a poor game from a scientific standpoint, it was very exciting, and our representatives showed up prominently. O'Brien and McEvedy did well for Kent, the latter being very conspicuous by his fine tackling of Alcock, the opposing three-quarter. Wetherell was quite in his best form, and Louisson, as half back for Surrey, was extremely good.

THE first Cup-Tie is against Bart.'s, on Tuesday next, at Richmond, and they are perhaps our most dangerous opponents. It is, we are sure, quite unnecessary to remind our men to turn up in force to support our team.

ASSOCIATION football has improved lately, but we feel sure that there is still room for progress in the same direction should some of the

"remarks" found in our sports column be taken to heart by the team. Against Weybridge we did fairly well to make a drawn game, and the loss against a good team of Casuals by 3 goals to 2, shows that we are much better than at the beginning of the season. The hard state of the ground in the latter match caused some miskicking in the back division. The forwards were better in front of goal, but do not act with enough decision. If the whole team were in better condition this fault would no doubt be to some extent rectified.

THROUGH the courtesy of Mr. Tom Bird, we are able to publish in another column a copy of an historic document which, in view of the present epidemic, will be of particular interest to all medical men. It was found amongst the family papers of an old Irish family of Huguenot descent.

WE congratulate Dr. Stevens on his recent appointment to the post of Obstetric Tutor to St. Mary's Hospital. Their Gazette, in chronicling the fact, gives a short account of his work and in conclusion says, "Readers will see from the above record that Dr. Stevens should prove a distinct acquisition to the teaching staff of the school."

WE notice that Mr. Chauncy Puzey, who was a Guy's man in the early sixties, having reached the age limit has retired from active work as one of the honorary surgeons to the Northern Hospital, Liverpool. That his services have been fully appreciated is shown by his being appointed Consulting Surgeon and placed on the Hospital Committee.

READERS who may have grown sceptical of our ever continuing the promised series of short practical papers on subjects of every day importance, will be relieved to see the paper by Dr. Cleveland in this issue.

A CONVERSAZIONE for first and second year students is to be held in St. Paul's Chapter House, on February 5th, at 5 o'clock, on the invitation of Canon Newbolt, to meet the Bishop of London, who will deliver an address. Those who wish to be present should write to Mr. F. W. Fawssett, Chapter House, St. Paul's, E.C. We hope every man who can get away will avail himself of the opportunity.

A COPY of the first number of "The Journal of Obstetrics and Gynæcology of the British Empire" has been sent to us. It is edited by Alban H. G. Doran, Esq. The list of his helpers contains the names of all the better known British obstetricians. Guy's men will notice with pleasure the names of Dr. Galabin and Dr. Horrocks amongst the collaborators, the latter contributing a paper on the "Contraction and Retraction of Muscular Fibres, with special reference to the Uterus" to this number. The names of the writers are a sufficient guarantee of the worth of the text, and the publishers are to be congratulated on the excellent *format* of the publication.

THE Dispensary Report for last year plainly shows that drugs, like dogs, have their day, disinfectants and dress alike are subject to the vicissitudes of fashion. The popularity of Ex. Malti cum Ol. Morrhuæ as a relish for rickety children, has increased with a bound, for whilst in 1900, £22 worth of this extract was used, during 1901 the amount eagerly consumed cost £62. Bottled Oxygen also enjoyed greater favour, costing the hospital £55 more than the previous year. In 1901, Bismuth Salts nearly doubled their popularity, and over £30 worth of Iron Alginate was prescribed for anæmic shop girls. On the other hand, Musk as a stimulant seems to have gone under a cloud, only £18 being used as against £45. It is surprising to see that the ever popular Pot. Iod. has also fallen off in demand, only a little more than half the previous amount being used. According to the report Urotropine's life has been one of meteoric brilliancy.

WE have been asked to insert the following:—"The St. Luke's Lodge of Instruction held its first meeting on Monday, the 20th inst., at the Criterion Restaurant. This lodge of instruction is the tangible result of the work done by a

committee representing the various medical lodges of the Metropolis, which was appointed last session to consider the subject. The principal business of the evening was the passing of the bye-laws, at the conclusion of which a vote of thanks to Bro. Rowell, the secretary of the original committee, upon whom has fallen the brunt of the work in connection with the preliminary organisation of the lodge, was received with acclamation, and ordered to be entered on the minutes. Bro. Achard was then appointed preceptor, and the second degree was rehearsed. The St. Luke's Medical Lodge of Instruction preposes to meet each Monday in the month, from October to May inclusive, with the exception of those falling in the Christmas vacation, Easter Monday and Whit Monday. The Secretary is Bro. Eyre, of Embankment Chambers, Villiers Street, W.C.

Obituary.

Wordsworth Poole,

M.B., B.C., C.M.G.

THE Students' Register of Guy's tells us that Wordsworth Poole entered on July 2nd, 1889, as a third years' man, to work for the Second M.B. Cambridge, which he passed in December of that year. He then entered the wards with a batch of other University men, among whom the names of J. B. Leathes, A. Shillitoe, G. Lawrence and H. C. Sharp are the first coming back to one's memory, and after dressing to Mr. Lucas, was "clinical" under Drs. Washbourn and Pitt in the last three months of 1893.

In April, 1894, having completed the two parts of the Third M.B. in December, 1892 and 1893, so graduating as M.B., B.C. Cantab., he was appointed A.H.S., having as his colleague the late G. Lawrence. It is, therefore, a peculiarly melancholy fact that Guy's now mourns the loss of Poole, the second of those two firm friends, yet men than whom it would be impossible to conceive two more opposed in character.

After serving the usual three months as A.H.S., Wordsworth Poole became house-surgeon to Mr. Golding-Bird, following R. H. Luce, who had been Mr. Golding-Bird's first H.S. on Mr. Durham's resignation. Mr. Golding-Bird's opinion of Poole, both as a house-surgeon and as a man, may be best gathered from the appreciative note which he has sent us, and with which we conclude this notice.

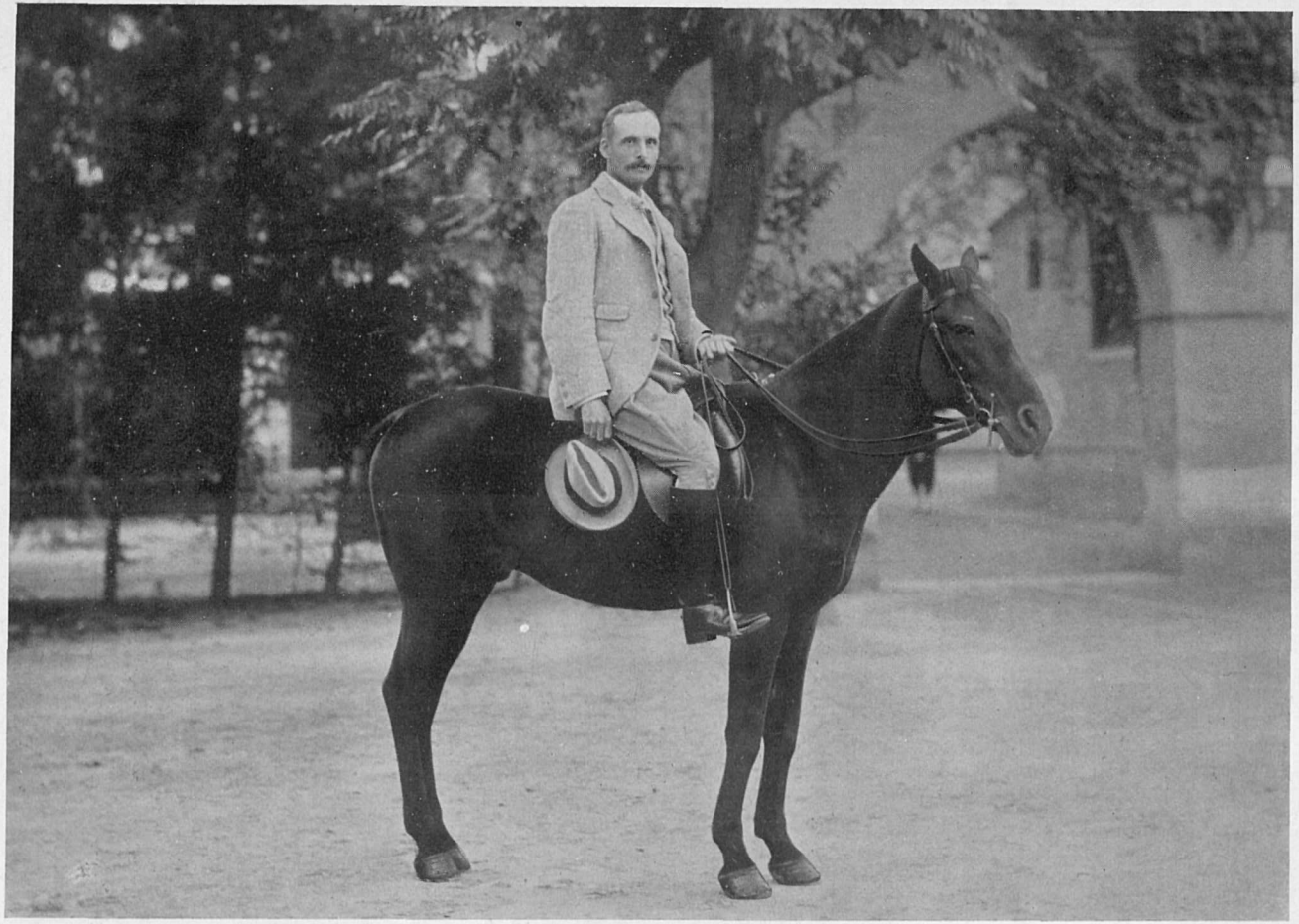
Finishing his term of office as H.S. on December 31st, 1894, Poole was not long idle, for on January 5th, 1895, he was selected by General (then Captain) Lugard as medical officer in the British Central Africa Protectorate, where he worked under Sir Henry Johnstone for three years. A brief holiday at home was followed by a second period of work in Africa, for in December, 1897, he was recorded for service in West Africa as Principal Medical Officer of the West African Field Force. For the excellence of his services there he was decorated with the C.M.G., as noted in the GAZETTE of January 6th, 1900.

About this time he was again in England, and talked most happily of his life in Africa, the vigour, ruggedness and danger of which were entirely to his liking. The writer well remembers congratulating him on his recent appointment as Physician to the British Legation at Pekin, and Poole answered that it might be rather orthodox and without incident after West Africa. How this opinion proved wrong is common knowledge, for soon after his arrival in Pekin the Boxer outrages occurred. Wordsworth Poole's name was among those wrongly reported murdered in the London papers in the summer of 1900. It is indeed unfortunate that this article can contain no account of this period of his life, but that his true worth was recognised is evidenced by the warm testimony of Sir Claude MacDonald in his report on the Siege of the Legation.

While still serving with the Legation at Pekin he fell ill with typhoid, and died early in this month at the early age of 33.

While at Guy's, Poole was perhaps best known as a constant and active supporter of the Association XI., for which he played as half-back in nearly all the matches during the four seasons, 1889 to 1893. It will be well remembered that he was constantly associated in the half-back line with A. M. Daniel and H. C. Sharp. The latter writes:—"Some of my happiest recollections of Wordsworth Poole was on the footer field, were we played half together. Full of pluck and go, he made a very sturdy tackler and a very difficult man to pass. Few men lived so happily on such spare means as he did, for as you know, his father gave up practice and went into the Church just before Wordsworth came to Guy's, so they were all in very straitened circumstances. I met an officer who came under his care when acting as P.M.O. in the West African expedition, and he spoke most highly of poor old Wordsworth. He said he saved his life and that of many others by his unremitting care and attention when they were laid up with dysentery. He always washed out the bowel with boracic. I dined with him before he went to Pekin, when he told me how he killed his first lion—in fact, I believe the only lion that has ever been seen or killed on that coast."

Wordsworth Poole had had a great gift of acquiring languages, which often stood him in good stead. He was a fluent French scholar, and when a student greatly enjoyed some tramps and adventures he had when he went through the Ardennes and the Vosges, on foot without any baggage. He also readily adapted himself to his surroundings, and being clever with his pencil, he



In Memoriam.—Wordsworth Poole, C.M.G., B.A., M.B., B.C.

one autumn produced a profusely illustrated and amusing account of his adventures when he went disguised as a hopper into Kent.

Three years of Africa had not damped the cheery ardour or altered the happy smile of Poole when last seen by the writer in 1900. There was still the same deep voice and resounding laugh as when, nearly ten years ago, we often had tea in the College, in the rooms of a mutual friend, who now writes :—"I fear I cannot tell you anything about Wordsworth. Like so many of those really decent friends, he talked but little about himself and his doings. Men who met him in various parts of Africa have told me he was always the same—ever cheerful, never despondent, whether rushing a zereba or attending the sick and wounded."

It is in the loss of men such as Wordsworth Poole, when met at Guy's, as perhaps only acquaintances in playing some game, that one feels that one's life is emptier : one pauses to think how straight he was, how true a life he led, what a lot he did in those few years given him, what one has missed in lost opportunities of making one's friendship closer.

The name of Wordsworth Poole will always be known at Guy's as one who ever did his best for his hospital, country, and the empire.

F.

A Personal Impression.

I wish that I could adequately express in words the feeling that I always had for, and the happy memory I shall always retain, of my old friend and House-Surgeon, Wordsworth Poole.

He and I worked together in the autumn of 1894 ; and though I have known in my time many a good house-surgeon—from the professional point of view, as good, I dare say, as he—yet Poole possessed a personal equation that stamped itself indelibly upon one's memory, and endeared him to all who came in contact with him.

High though his surgical abilities were—and I will say, as I knew him, second to none of his standing—I think it likely that his steady promotion in the public service was quite as much due to the magnetic influence that he possessed as to his professional attainments. To speak to him for a short time was to be drawn to him, and at once it was felt that one had found a genuine friend, to be trusted in all weathers.

His bright and happy smile, his almost boyish face, and his particularly brilliant and gleaming eyes, that seemed to pierce the person he was addressing, at once bespoke him a straightforward, trusting, trustworthy and open-hearted gentleman, about whom the suspicion even of anything underhand was quite impossible.

Yet with all this he had at times a shyness, almost girlish, especially with strangers, but it arose from no false modesty, but from his wish always to efface himself. He never pushed himself with emphasis to the front, and never acted as though he possessed the slightest opinion of his position or abilities, though when his duties were defined, he never in his performance of them ever swerved in the slightest degree from what he thought right and honourable, and where others were concerned he would insist, but with that gentle insistence that always wins, on everything, small or great, being perfectly performed.

Thus it was that his dressers looked upon him with intense trust, and he held the affections of the whole firm, from surgeon to nurses ; and in arranging the work of the firm, whether in the manifold duties of the wards or in the preparations for an operation, no time was ever lost, nothing was overlooked, and work was rapidly got through without a hitch. Yet Poole was never in a hurry !

When once his personal qualities were recognised, it is no surprise that he obtained steady promotion in his public work, where trustworthiness was an essential of service, till it culminated in that prized position in foreign civil employ, the physiciancy to the Pekin Embassy.

To Poole's life in the country—for his father was the well known practitioner in Sidcup—may be traced his love of sport. I am unable to say if he were a sportsman from the cricketer's or footballer's point of view, but sport with the gun he keenly relished. I well remember his delight on receiving notice of his first public appointment, just after being house-surgeon, on the Shiré river, in British East Africa—a distinctly unsettled part of the country. We talked the matter over, and I was surprised to find him eager to go, as there was the chance of seeing active service on the field. I had never thought of him as a combatant ; but his sporting instincts were aroused to the full as he informed me of the fact that he must be leaving immediately, his predecessor having just been eaten by a lion ! Poole made no verbal comment on this : his expressive face was enough.

I heard more than once from him, when in harness in East Africa, and the careful notes he sent me of some of his cases, showed that he was doing his work in no perfunctory way, but as thoroughly and scientifically as his primitive surroundings would permit.

How he distinguished himself in the late siege of the Embassies in Pekin is known to all. He showed conspicuous bravery from the first of his seeing active service. His gallant deed of carrying ammunition to the combatants, under fire, when storming a certain Arab slave stronghold, has been publicly mentioned.

If I may speak for myself, I would add that in Wordsworth Poole I have lost a friend for whom I had a great affection and a great respect, and in him the profession has lost a typical English gentleman, for *Wordsworth Poole was brave and good.*

C. H. GOLDING-BIRD.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

The Debating Society.

The last meeting of the above society was preceded by a dinner given in honour of Mr. W. C. C. Pakes by the committee. Dinner over, Mr. Gibson proposed the health of the guest of the evening in a few but well-selected words. Mr. Pakes being aware of the fact that he was expected to speak at length later in the evening briefly thanked the company for the enthusiastic way in which they had drunk his health. An adjournment was then made to the smoking-room, where, amidst the plaudits of about seventy members, Mr. Pakes took the chair. The minutes of the previous meeting having been read and confirmed, Mr. Thompson, armed with a copy of the rules and a quiver of curious quibbles, commenced, in a rasping voice, an attack upon the Hon. Secretary. However, the volunteer experience of the latter, aided by the consummate tactical genius of the Chairman, enabled an efficient answer to be given.

Mr. Pakes then called upon Mr. Brydone to propose "That the time is ripe for the abolition of the Monarchy and for a Republic to be established in its stead." The hon. proposer, in an excellent speech, urged his views with much grace upon an attentive house. He pleaded that the excellence or otherwise of the present Ruling House was not called in question, but that the question of the Monarchy must be decided on utilitarian grounds.

Dr. Eason, in an impromptu speech, replied. Had Dr. Eason not elected to spend his time in chasing the De Wet-like shadows across the wonder-struck pupils of inoffensive school children and in splitting hairs with eminent ophthalmic surgeons, we venture to think he would by this time be dozing upon the Government benches at Westminster.

The Hon. Secretary having in a few words raised some points worthy of discussion, was succeeded by Messrs. Bolus, Gibson and Thompson.

The Chairman then called upon the Rev. Mr. Bailey to offer a few words. Mr. Bailey spoke briefly but to the point.

Mr. Hodgson having dragged a certain Mr. Bowen's name into the discussion, Mr. Black jumped up and informed the House that the said Mr. Bowen had had his leg amputated. He also gave gratuitous information as to the unfortunate gentleman's salary.

Dr. Spriggs voiced the feeling of the members present in regretting the departure of the Chairman to South Africa.

Mr. Brayne, in a comic interlude, begged the House to give close attention to his most important remarks. They did so, and thought of Hippolyta's criticism of Bottom's jerky oratory, "He hath played on his speech like a child on a recorder: a sound, but not in Government."

Mr. Brydone then subjected the speeches of his opposers to a destructive and telling criticism. The House then divided. There voted for the motion, 17; against, 38. The motion was therefore lost.

Mr. Thompson then moved a hearty vote of thanks to Mr. Pakes for presiding. He said that sorry as the society was to lose Mr. Pakes, he hoped he would win fresh honours for Guy's in the New Colonies.

Mr. S. Hodgson thanked Mr. Pakes for the great services he had rendered to the society since its commencement.

Mr. Pakes, who was warmly applauded on rising, said: Gentlemen, the Debating Society has now been in existence nine years and six months. During the whole of that time we have been honoured by having for our President that eminent Guy's man, Dr. Pavy. (Applause). I need scarcely say, and I think I can say it without egotism, that many illustrious men have served as vice-presidents. The officers of the society have always been hard-working and have always done their best for the advancement of its objects. There have, of course, been periods of depression, but I am sure the society has justified its existence. I can remember a few years ago that at times it was sometimes painful, even ludicrous, at the Physical Society, to hear men attempting to express their opinions. But the Debating Society has greatly improved this. We hear better expression of ideas now, and men having had the opportunity of speaking before their fellow-students at the society, are able to state their case in a clearer manner. (Hear, hear). I have, gentlemen, seen men who could, the first time they spoke, scarcely string three words together, blossom out, in the society, into quite good orators. And that, I take it, has been one of the main objects of the society. Here men of different years, of different opinions and of different tastes can meet on common ground and discuss their differences together. In my opinion the Debating Society is one of the best societies in the hospital. (Applause). With one slight lapse between the time when I served on the committee and when I was elected a vice-president, I have been intimately connected with the society from its foundation, and I now greatly regret that I must sever my connection with it. I very greatly appreciate the kind words that have been spoken about me this evening, and can only say that when I come home on furlough, if you are good enough to ask me, I shall hope to preside over you again. In conclusion, gentlemen, I should like to say how very greatly I appreciate the many kindnesses I have so constantly received from all connected with the society. (Loud applause).

Papers by Guy's Men.

A Lecture on Disinfection. By W. C. C. Pakes, D.P.H.—*The Clinical Journal*, 15th January.

A Case of Acute Pulmonary Œdema. By F. W. Rowland, M.D. Durh.—*Lancet*, 25th January.

Pernicious Anæmia. A Case in Practice. By J. F. Rymer.—*Journal of the British Dental Association* for January, 1902.

In Lighter Vein.

Debating Society.

Farewell to Mr. Pakes.

Gorgeous Spectacle.

After a good dinner and plenty of health drinking, the above society retired to the smoking room, and, with Mr. Pakes (wearing a beautiful cuture of bacillus coli in his buttonhole) in the chair, commenced a most brilliant debate. The presence of many members of the staff enhanced the beauty of the scene. The subject before the house was "That the time is ripe for the institution of a republic," and generally speaking, down with everything.

Mr. Brydone (the opener) said that if anyone could mention a fact, about this or any other subject on this earth, with which he was not perfectly familiar, he (Mr. Brydone) would pay that gentleman half-a-crown.

Dr. Eason (the opposer) said that he was oculist to the Royal Family and all the other crowned heads of Europe, Asia, Africa ——

Dr. Washbourn (interrupting) said that talking of Africa reminded him of an amusing story a bishop told him about sleeping at a Boer farmhouse.

Mr. Gibson, unfortunately absent from the previous debate, commenced to read a speech he had written for that occasion. Being called to order by the chairman, insisted on singing the national anthem.

Mr. Symonds informed the house that he was a prince of good fellows.

Mr. Brayne (sobbingly aphasic) informed the house that he did not know the King (applause); adding, "Long live Alexandra Regina."

Dr. Horrocks (who had been peacefully snoozing) at once leapt to his feet, and, in a state of the wildest excitement, cried "Eh! What's that! Ma gracious, I must have been dreaming."

Mr. Stanley Hodgson next arose and said "Hiccup, hiccup, hiccup" (sensation).

Dr. Washbourn said that Mr. Hodgson's speech reminded him of an amusing cathedral he met in a Boer farmyard; what the bishop did say was ——

Mr. Thompson (who wore his world-renowned travelled-stained trousers) stated that he was an M.B. Vict., and therefore voted for the Royal Family. On being asked if that was why he never brushed his hair, he was understood to say that he withdrew nothing.

Dr. Washbourn then told an amusing story about a bishop who slept in a Boer cathedral.

Dr. Bruce (who is still suffering from the results of the Christmas festivities) was not there, and consequently did not speak.

Mr. Bolus could not be kept down.

Dr. Washbourn said that when he was a Boer bishop he passed a cathedral. (Uproar).

[House left sitting.]

THE BIRD OF PREY.

Correspondence.

To the Editor of Guy's Hospital Gazette.

South African Memorial.

Dear Sir,—Some time since, in response to the appea of the then Editor of the Guy's Hospital Gazette, I sent in a small contribution to the Fund which has its object in the erection of some Memorial to the Guy's men who fell in South Africa.

I have often hoped to see some announcement in your columns relative to this memorial but I have been as often disappointed. May I ask you what you intend to do with the money which you have collected—and why you don't do it?—Yours faithfully,

STANLEY HODGSON.

201, Brixton Hill, S.W.,
27th January, 1902.

Pass List.

Second Conjoint Examination.

J. M. Barronuevo, A. M. Benett, J. H. Cheney, H. P. Costobadie, P. A. S. Dyson, A. Leeming, A. S. Littlejohns, W. Reeve, E. N. Routley.

First Examination.

Chemistry.—F. Chilton, L.D.S., H. P. Hooper, L.D.S., E. Morgan, F. Morres, C. M. Ockwell, H. A. Pallant, C. W. Randall, L.D.S., R. Roberts, L.D.S., G. Wacher, W. H. Yeo, L.D.S.

Practical Pharmacy.—F. Barnes, C. J. S. Dismorr, E. H. Griffin, H. F. Hatfield, C. H. Reinhold, J. F. Rey, F. M. V. Smith, F. J. Turner.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee :—

Clinical Assistants in Medical Wards.—Messrs. E. Faulks (Dr. Hale White); C. J. Pinching (Dr. Pitt); D. H. Trail (Dr. Perry).

Clinical Assistants in Surgical Wards.—Messrs. J. M. Bickerton (Mr. Howse); E. H. Griffin (Mr. Golding-Bird; R. G. Anderson (Mr. Jacobson).

Ophthalmic Dressers.—Messrs. G. B. Churchill, M. Coplans (Mr. Higgens, February 1st); T. M. Smith, C. R. Howard (Mr. Brailey, February 1st); G. Moir, C. Fraser (Mr. Higgens, March 16th); C. H. Denyer, B. Rahim (Mr. Brailey, March 16th).

Surgeons' Dressers.—Messrs. C. H. Bubb, H. Johnson, H. C. Winckworth, J. S. Cooper, J. Braithwaite, G. L. Buckeridge (Mr. Howse); J. T. Hicks, N. I. Spriggs, T. C. Lucas, A. R. Wilson, H. M. Woodward, H. S. Brown (Mr. Lucas); C. M. Anthony, E. N. Jupp, C. R. Shattock, R. E. Brayne, C. E. Adams, L. S. Glanville (Mr. Golding-Bird); F. C. Robinson, L. H. Ackroyd, A. R. Brailey, J. Goss, D. R. Pike, P. W. Hamond (Mr. Jacobson).

Dental Surgeons' Dressers.—Messrs. A. H. E. Wall (February-March); W. J. Davies (March-April); A. C. Osburn (April-May).

Externs.—J. B. Copland, H. Tipping, C. H. Robertson, E. W. Strange, A. J. Beadel, L. H. Moiser (February); A. Moon, F. J. Turner, H. S. Jones, B. H. Wedd, A. P. Piggot, W. F. Box (March); K. Anderson, S. L. Pallant, G. W. Smith, W. L. M. Day, A. J. Urquhart, C. H. Dawe (April).

CIVIL.

BEDDARD, A. P., M.D., M.R.C.P., has been appointed Physician to the West London Hospital, *vice* Dr. F. G. Drewitt, resigned.

BEDFORD, GEORGE H., L.S.A., has been appointed Medical Officer of the Rothbury Union.

BROWNE, T. W. STANLEY, L.R.C.P. Lond., M.R.C.S., has been appointed District Poor-law Medical Officer for Chatham.

LITTLEWOOD, J. O., M.R.C.S., L.R.C.P. Lond., D.P.H., has been appointed Visiting Medical Officer to the Nottingham and Nottinghamshire Sanatorium for the Treatment of Consumption, Sherwood Forest, Mansfield.

STEVENS, THOMAS G., M.D. Lond., F.R.C.S. Eng., M.R.C.P. Lond., has been appointed Obstetric Tutor to St. Mary's Hospital.

WRIGHT, G. ARTHUR, M.B. Oxon., F.R.C.S. Eng., has been appointed Consulting Surgeon to the Manchester Children's Hospital.

MILITARY.

Volunteer Artillery—1st Dorsetshire (Royal Garrison Artillery); SURGEON-CAPTAIN A. KINSEY MORGAN is promoted to be Surgeon-Major.

Sport.

Rugby Football.

GUY'S v. OLD LEYSIANS.

Played at Honor Oak on January 4th. Cutler won the toss, and Guy's defended the pavilion end, a strong cross wind being slightly in their favour. The Old Leysians kicked off, and Morgan returned into touch about halfway. Guy's quickly attacked, and when the game had been in progress about two minutes, Morgan got over in the corner. He took the kick himself, and landed a good goal. O'Brien made his mark from the kick-off, and found touch in his opponents' twenty-five. The Old Leysians played up hard, and by good dribbling gained a a good deal of ground, the Guy's tackling being uncertain. The home forwards were now getting the ball out to their backs, and from a good passing bout, Morgan was able to score again. He failed with the kick, from a difficult angle. Following free kicks to both sides, Guy's pressed and the three-quarters had many opportunities, which were, however, spoiled by the tendency of the centres to run across the field. The Old Leysians made a fine rush, which was stopped by O'Brien, who found touch with a good kick. Just before half-time McEvedy made a fine run, following some good combined play, and scored a third try. This Morgan had little difficulty in converting. Half-time arrived with the score, Guy's, 2 goals, 1 try, Old Leysians, 0.

Thomas kicked off for Guy's, and even play followed for some time. At length the home forwards made a strong attack, and Glendinning picked up and scored a try far out. Harrison took the kick, but the ball fell short. Soon after the re-start Wetherell got over, and scored between the posts; there was a loud appeal for offside, but the ball having come to Wetherell after touching an opponent, the try was given. Morgan failed to convert from an easy position. Following a free kick to the Old Boys, Thompson came away with a good dribble, but the ball was touched down before he could get to it. The Old Leysians now did a good deal of pressing, but were never really dangerous. The home forwards brought relief with a combined dribble, and the ball coming to O'Brien, that player threw the ball out to Morgan, who had no difficulty in crossing the line. Harrison took the kick and landed a fine goal. Guy's continued to press, and but for wild passing, caused doubtless by the greasy state of the ball, should have scored more than once. However, just before the finish McEvedy put in a good run and scored another try. Harrison was not successful with the kick. Shortly after this time was called, with the score—Guy's, 3 goals, 4 tries (27 points); Old Leysians, nil.

GUY'S v. ROSSLYN PARK.

In this match played on January 18th at Honor Oak Park, Morgan was absent from the team, his place being

taken by F. E. Walker. Guy's kicked off and soon began to press, and after a good run by Alcock, Rosslyn Park were forced to touch down. The game then remained in the centre of the field for some time, until after good passing by our opponents' three-quarters, Bailey made a good run down the touch-line, but was well collared by Walker. Good forward work soon brought about relief, and Guy's were attacking again. Alcock taking the ball from a loose kick by an opposing three-quarter, made a strong run down the touch-line, and scored on the corner. Harrison was unsuccessful with the kick at goal. After the drop-out the play was fairly even, until from a long kick the ball went into touch close to our goal-line. Then first one side and then the other took the ball up and down the field by forward rushes. Eventually from a scrum, Wetherell made a good opening and passed to Alcock, who scored wide out. Again Harrison failed with the place kick. Shortly after this half-time was called with Guy's leading by 2 tries to nil.

In the second half Rosslyn Park pressed for some time, but Thomas intercepted a pass, and by good footwork carried the play to the other end of the field. The opposing forwards immediately rushed the ball back, but Harrison saved well. From this time the hospital had much the best of the play. Good passing by Payne, O'Brien and Walker, enabled the latter to score, but O'Brien failed with the kick; while a little later Wetherell with a good run scored, but again O'Brien's attempt at goal was a failure. Then some passing by Wetherell, McEvedy and Alcock, resulted in the latter scoring behind the posts, after a brilliant run. O'Brien kicked the goal. A similar piece of play soon enabled Alcock to score on the corner, but Harrison's place kick was unsuccessful. Shortly before time Thomas scored in a good position, and Harrison placed the goal, Guy's thus winning by 2 goals, 5 tries (25 points) to nil.

The great feature of the game was the strong running by Alcock, whom the opposing backs were hardly ever able to stop. The whole team, however, played well, the forwards in particular displayed plenty of vigour, while their loose work was distinctly good. Team:—

E. M. Harrison (back); F. E. Walker, A. O'Brien, P. F. McEvedy, F. Alcock (three-quarter backs); O. V. Payne, M. C. Wetherell (half-backs); H. A. Cutler, T. P. Thomas, R. C. Lawry, A. R. Thompson, R. G. Anderson, B. Glendinning, E. H. B. Milsom, E. L. Ward (forwards).

GUY'S 2ND XV. v. BECKENHAM.

This return match was played on Saturday, January 25th, on our ground, and resulted in a win for Guy's by 3 tries to 1 try.

Winning the toss, we played with both wind and sun in our favour in the first half, but only succeeded in scoring once—the result of a good dribble by Pye-Smith, ending in Brown picking up and getting over—Rendall failing to convert.

In the second half play was very fast for a time, and Beckenham from a scrum in our twenty-five, equalised almost under the posts, the kick failing. Both sides missed scoring from penalties, and then Cutler who had taken Lawry's place at half, made a splendid individual run, and gained a try wide out. Shortly after Tolhurst got over in the other corner, but just failed to convert.

Result.—Guy's, 3 tries (9 points); Beckenham, 1 try (3 points). Team:—

R. D. Bridger (back); S. L. Pallant, C. D. Pye-Smith, E. N. Jupp, H. S. Brown (three-quarter backs); R. C. Lawry, A. E. Kynaston (half-backs); A. H. E. Wall, E. L. Ward, R. M. Rendall, A. M. Tolhurst, T. B. Layton, C. J. Pinching, H. Watts, F. Cutler (forwards).

REFEREE.—Mr. M. G. Louisson.

REMARKS.—Bridger was not in his best form at back, but nevertheless was safe, his tackling being good. The three-quarters were very equal. Lawry made his début at half, and was the most conspicuous man on the field, his passing out to Kynaston enabling the latter to show to the full his ability to take passes of every description. Of the forwards, Wall, Pinching and Ward were the pick, but the rest played well, though Beckenham had the better of the tight scrums, and were heavier than our men.

Association Football.

GUY'S v. OLD EASTBOURNIANS.

(GUY'S, 6 GOALS; OLD EASTBOURNIANS, NIL).

This match was played at Honor Oak Park on Saturday, January 4th, and ended in an easy victory for the hospital. Our first goal came from a good shot of Litchfield's, and Frankenburg a little later hit the bar with a swift shot, which scored. Barber was responsible for the remaining four, and completely ran through the opposing halves and backs, and a somewhat one-sided game ended as above stated. Team:—

H. D. Wyatt (goal); T. Edey, A. D. Crofts (backs); A. F. Denning, J. Goss, L. H. Frankenburg (halves); E. Wragg, P. C. Litchfield, H. Barber, E. L. Norton, P. A. Peall (forwards).

GUY'S v. BECKENHAM.

DRAWN, 3–3.

This match, played at Honor Oak Park on Saturday, January 18th, ended in a draw of 3 goals all. Both teams were playing a man short, and the game was of a somewhat straggling nature for the first ten minutes. From a pass by Denning, Wragg took the ball well down the wing, and centring across the goal's mouth, enabled Norton to score an easy goal. Beckenham then worked hard, and from some good forward play, scored their first goal. Shortly after Barlow with a swift high shot added a second, and before half-time Barber, after some good dribbling, obtained the third goal.

Crossing over with 3–1 in our favour, play was fairly equal, and remained so till close upon time, when the hospital showed a lack of keen football, a fact which our opponents readily took advantage of, and by two combined

forward rushes, added two more goals, and thus equalised. Nothing was further scored when time was sounded.

The team as a whole certainly did not play up to the form shown in previous matches. The forwards were weakened by having to play one short. Denning was the best half, but the backs were not really safe, and Edy should get rid of the ball sooner, instead of dribbling up the forward line as at times he did. Team :—

E. A. Collins (goal); T. Edey, H. R. Wilson (backs); A. F. Denning, L. H. Frankenburg, H. Bacon (halves); E. Wragg, S. H. Barlow, H. Barber (Capt.), E. L. Norton, P. H. Peall (forwards).

GUY'S v. EASTBOURNE.

With the three regular halves away, and Barber absent from centre forward, the hospital team travelled down to Eastbourne on Wednesday, January 22nd. The opening stages of the game were rather slow, and it was not till the team had overcome a lethargic state, probably produced by imbibing large quantities of sea air, and got accustomed to the rather unfamiliar sun, that the hospital forwards got together and scored through Norton. Guy's continued to have most of the game, the whole team playing well together, and although Eastbourne once or twice gave Collins some difficult work, they were unable to beat him. Before half-time Norton scored again for the hospital, who crossed over leading 2 goals–love.

On resuming, the game continued to go in favour of Guy's, and Norton added two more points. Ten minutes before time the Eastbourne forwards got away, and scored through their inside right. Nothing further was added to the score, and time found Guy's the winning team by 4 goals to 1.

REMARKS.—Norton played a good game at centre-forward, kept his men together, and shot well. The right wing was often prominent. All the halves played a hard game, and tackled well. The backs were safe, and Wilson's kicking was a feature of the game. In goal, Collins played one of his best games. Team :—

E. A. Collins (goal); A. R. Wilson, T. H. Edey (backs); C. Martin, P. Pedrick, L. H. Frankenburg (halves); E. Wragg, P. C. Litchfield, E. L. Norton, H. Barlow, P. A. Peall (forwards).

INTER-HOSPITAL CUP TIES.

A. London v. St. Thomas's.
B. Winner of A v. Charing Cross.
C. St. George's v. St. Mary's.
D. Middlesex v. University.
E. Guy's v. St. Bart.'s.
F. Winner of C v. Winner of D.
G. Winner of B v. Winner of E.

Final.

Winner of F v. Winner of G.

1st Round to be played by February 1st.
2nd " " " February 15th.
Semi-Final " " March 1st.
Final " " March 8th.

Chapel News.

On Sunday, February 9th (Quinquagesima) the preacher at evening service will be the Rev. H. S. Woollcombe, Head of the Oxford House, Bethnal Green.

On February 12th (Ash Wednesday) the Bishop of Rochester will give the first of the Lenten addresses at 8.15 p.m.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane* :—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

H.R.M., HASTINGS.—Tubercle bacilli were present in this sputum in large numbers, with numerous clumps.

T.M.W., HOOK NORTON.—On section, this breast shows two large, smooth-walled cysts, and the intervening stroma is made of dense, fibrous tissue. A few atrophied lobules of mammary tissue remain, but there are no signs of malignant growth.

J.M.W., HOOK NORTON.—No tubercle bacilli were found in this specimen,

H.R.M., HASTINGS.—A fair number of tubercle bacilli were found in this specimen.

J.R.A., CHADWELL HEATH.—The blood serum culture contained an abundant growth of staphylococci; but the Klebs Loffler Bacillus was not found.

PATHOLOGIST.

Death.

HILLS.—On January 18th, at the Chantry, Norwich, suddenly, William Charles Hills, M.D. Aberd., aged 73.

ED.—D. G. G.

Contents.

	PAGE
Diagnosis of Small-pox: Clinical Lecture by Dr. Washbourn	65-69
Notes from Dr. Shaw's Out-Patients	69-70
The Lepers' Home at Spanish Town	70-71
Papers by Guy's Men	71
A Punch and Judy Show	72-74
Charles Murchison's Scholarship in Clinical Medicine	74
Passim	75-79
Tempora Acta	79-80
Nursing News	80
In Lighter Vein	80
The Dental Society's Dinner	81
Appointments	81
Novelties	82
Types	82-83
From the Gazette's Special Pathologist	83
Chapel News	83
Pass List	83
Sport: Rugby Football—International Rugby Cup-Tie—First Round—Guy's v. St. Bartholomew's	83-84

Calendar of Coming Events.

February, 1902.

Sat. 15.—Messrs. Lucas and Lane's take-in; Drs., J. T. Hicks and N. I. Spriggs; Cl., S. Hodgson.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Lennox, away.
II., Lennox, II., home.
III., Old Alleynians, III., away.
G.H.A.F.C., II., City of London School, away.
G.H.P.P.S., Pathological Meeting.

Mon. 17.—1.15 p.m., Clinical lecture by Mr. Symonds.

Wed. 19.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., III., Blackheath School, away.
G.H.A.F.C., I., Emerite, home.

Thur. 20.—Messrs. Golding-Bird and Dunn's take in; Drs., C. M. Anthony and C. R. Shattock; Cl., H. C. Keates.
G.H.C.U., Address by Rev. J. C. Elliott, M.A.

Sat. 22.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Croydon, away.
III., King's College "A," away.
G.H.A.F.C., I., Reigate Priory, away.
II., Dulwich 2nd XI., home.

Mon. 24.—1.15 p.m., Clinical lecture by Mr. Targett.

Wed. 26.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.

Thur. 27.—Messrs. Jacobson and Fripp's take-in; Drs. A. R. Brailey and D. R. Pike; Cl., P. N. B. Odgers.

March.

Sat. 1.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Marlboro' Nomads, home.
II., " II., away.
G.H.A.F.C., I., Idlers, home.
II., Leavesden Asylum, away.
April Appointment List opened.

Guy's Hospital Gazette.

FEBRUARY 15, 1902.

Diagnosis of Small-pox.

CLINICAL LECTURE BY DR. WASHBOURN.

November 23rd, 1901.

Gentlemen,—The diagnosis of Small-pox is sometimes easy, often difficult, and always a matter of great importance. In almost all cases, during the *incubation period*, there is nothing to call your attention to the fact that the patient is in any way ill.

During the *initial stage* there are often many symptoms which suggest to you small-pox, but it is only in exceptional circumstances that you are able to diagnose the disease during this stage. The principal symptoms, you remember, during the initial stage, are rigors, vomiting and pyrexia.

There are a number of diseases which, during this initial stage, are likely to be mistaken for small-pox. One of these is pneumonia. You know that pneumonia begins frequently with a rigor, just in the same way as small-pox, and for some days there may be no other symptom. We have, for instance, at the present time, a patient in John ward who was suddenly taken ill with shivering and high temperature, and we could find nothing else the matter with him until about four or five days after admission, when definite symptoms of pneumonia arose. In pneumonia, as a rule, in the early stage, there is something to point to the lung being affected. Either the respirations are very rapid out of proportion to the temperature, or the patient suffers from cough, or there is severe pain in the side. But in some cases of pneumonia in which the disease begins in the central part of the lung, and does not come to the surface, and there are no physical signs, you may easily mistake the condition for the initial stage of small-pox.

Another disease which is liable to be mistaken for small-pox in the early stage, is influenza. Influenza often commences suddenly with a

high temperature, and the patient feels exceedingly ill, but, as a rule, rigors are absent, though there may be severe pain in the back. You can quite understand that in certain cases it is impossible to distinguish between the initial stage of small-pox and influenza. In influenza there may be catarrhal symptoms or bronchitic symptoms, which should put you on your guard.

Another condition which sometimes leads to difficulty is acute nephritis. I am referring to the cases that come on quite suddenly with severe pain in the back, high temperature, and perhaps a rigor. Such cases you might easily mistake for small-pox, but an examination of the urine shows at once what you are dealing with.

Enteric fever may also be mistaken for small-pox. As a rule, in enteric fever, the attack comes on gradually, and the patient cannot tell you exactly when he was taken ill. But there are certain cases of enteric which begin quite suddenly, and in which there is a good deal of pain often situated in the back. In the early stage of enteric there would not be rose spots, but there might be enlargement of the spleen and possibly diarrhœa.

There is another condition that ought not to be mistaken, but certainly is frequently mistaken, for the early stage of small-pox, namely, ordinary lumbago. But in that condition there is no pyrexia, the patient is not really ill, and consequently the mistake ought not to be made.

You remember that in the initial stage there are certain prodromal rashes which occur from time to time, and which may lead to difficulties in diagnosis. For instance, a scarlatiniform initial eruption might very easily be mistaken for scarlet fever. In order to diagnose between scarlet fever and the initial stage of variola with a scarlatiniform eruption, there are several points which will help you. In scarlet fever, as a rule, the patient has a sore throat, which is often the first symptom that he complains of. Usually there is a considerable amount of redness and œdema of the fauces, and there may be actual exudation. In a mild case of scarlet fever you may find very little in the throat, the patient not complaining of pain, nor is there any redness, or swelling, or exudation. However, it is not a mild case which is likely to be mistaken for small-pox, but an acute severe case coming on suddenly with severe symptoms. In such a case you generally get a marked affection of the throat. Scarlet fever not at all infrequently begins with vomiting, in that way still more resembling the initial stage of small-pox.

The eruption in scarlet fever, as a rule, is not the same in character as that in small-pox. A scarlet fever eruption first affects the chest and neck, and then the rest of the body, with the exception of the face, the palms of the hands, and the soles of the feet. In variola, the eruption is not distributed in the same way; it affects especially the extensor surfaces, being particularly marked along the line of the extensor of the great toe, and in some cases it is only marked in the triangular, area about which I have already spoken, with its base at the crest of the ilium and its apex at the pubes.

A morbilliform or macular initial rash may be mistaken for measles, either ordinary measles or German measles. In ordinary measles the eruption is macular consisting of irregular blotches of erythema which affects especially the face. It is rare to get the face free, with the rest of the body affected. The eruption comes out on the fourth day, at a later period than in small-pox, for, as you remember, the initial stage of small-pox lasts only forty-eight to seventy-two hours. Before the eruption comes out, there is generally a prodromal period of catarrh; the patient complaining of catarrh and bronchitis with fever for three or four days before the eruption appears. In the macular eruption of small-pox the face is often not affected. So that the fact that the face is not, as a rule, affected in small-pox, and that the eruption comes on at a much earlier stage than in measles, would generally be sufficient to enable you to make your diagnosis.

There is another thing which may help you in measles, and that is, the presence of what are called Koplik spots, little minute whitish-yellow spots which are seen upon the buccal mucous membranes. They, however, only

occur at the early stage of measles, and, as a rule, they have disappeared by the time that the eruption has come out.

German measles ought not, as a rule, to cause much difficulty, because in German measles the condition of the patient is never very serious. The symptoms are usually quite slight; there is only slight pyrexia, and the patient does not feel ill. The glands of the body are generally enlarged, especially those behind the mastoid process and those in the neck.

Typhus fever may be mistaken for small-pox either before the eruption of typhus has come out or afterwards. The eruption of typhus comes out on the fifth day, and the patient almost always has a severe prodromal period before the eruption occurs; in small-pox the patient is ill for only a short period before the initial eruption comes out. The eruption of typhus is not at all unlike some of the initial eruptions of small-pox, and might, I think, easily be mistaken, but the period at which it comes out is an important distinction.

Besides Scarlet Fever, Measles, German Measles, and Typhus, there are various forms of erythemata which may be mistaken for the initial rashes. Such erythemata are produced by certain drugs, or by articles of food. For instance, the erythema produced by copaiba, belladonna, or by so called ptomaine poisoning, or the eruption of syphilis. The copaiba eruption is a patchy erythema, and, as a rule is not accompanied by any severe constitutional disturbance. The eruption due to belladonna is more like that of scarlet fever, but is much more universally distributed. It may be attended with pyrexia. However, in belladonna poisoning there is generally dilatation of the pupils, and not infrequently a peculiar delirium, and an enquiry into the history of the case ought to help you considerably.

In syphilis it is the early macular eruption which may give rise to error, but in these cases the fever is slight and careful inquiry into the history soon reveals the nature of the case.

Those are the principal conditions that are likely to be mistaken for small-pox during the initial stage.

The next thing to consider is that special variety of small-pox which occurs during the initial stage—I mean *hæmorrhagic small-pox*. This is exceedingly likely to be mistaken for purpura. In considering the diagnosis of hæmorrhagic small-pox as distinguished from purpura, the best plan will be to consider what are the conditions which generally give rise to purpura. Purpura is not a distinct disease, but consists of a variety of diseases due to different causes. Purpura occurs in various fevers, and in small-pox you may look upon it, more or less, as an accidental accompaniment of the disease. It may occur in diphtheria, in some cases of scarlet fever, though rarely, and in various forms of septicæmia. In septicæmia and in other fevers the purpura, as a rule, does not come on quite so early as that in hæmorrhagic small-pox, which, I think, will help you considerably in the diagnosis. I remember one case of scarlet fever followed by septicæmia, in which there was marked purpura and hæmorrhages into the skin and joints, and from the mucous membranes of the gums and lips.

Purpura occurs in peliosis rheumatica, which generally arises in patients who have suffered from rheumatism, and is often accompanied by pain in the joints, but the constitutional disturbances are not so severe as in hæmorrhagic small-pox.

Then again, certain drugs may produce purpura, as, for instance, iodides; such drugs would not cause severe constitutional disturbance, nor would they give rise to fever.

The presence of various toxic products in the blood may produce purpura, for instance, in severe diseases of the liver or kidney. But these conditions, as a rule, are not likely to give rise to much confusion, because there is always other evidence of the causation of the purpura.

In various blood diseases, such as anæmia, or leucocythæmia, purpura is not uncommon. You also get purpura in the condition in which it is called scurvy. Scurvy is caused by the absence of fresh vegetables, and there is generally effusion of blood into the subcutaneous tissue. Another condition in which purpura occurs is hæmophilia, but in this affection you

find on enquiry that the patient has bled very readily all his life.

Then there is idiopathic purpura, purpura simplex, and purpura hæmorrhagica. In purpura simplex hæmorrhages occur in the skin, and in purpura hæmorrhagica also in the mucous membranes.

Most of these cases at the commencement are not at all severe, the patient has very little pyrexia and very little constitutional disturbance. But there is a form of purpura hæmorrhagica which is called *purpura fulminans*, in which the patient dies in two or three days with severe fever and other constitutional disturbance. Such a condition may very easily be mistaken for hæmorrhagic small-pox, and it is a question as to whether some of these cases are not really cases of hæmorrhagic small-pox. I do not know any mode of distinguishing between a case of purpura fulminans and a case of hæmorrhagic small-pox if the patient should die within two or three days before there has been time for the eruption of small-pox to appear.

There is another form of purpura, namely, Henoch's purpura, a feature of which is hæmorrhage from the intestine, and colic.

In any case of doubt you only need to wait for a short period, for on the third day the typical eruption of small-pox appears. You must remember that during the initial stage it is almost absolutely impossible to form a diagnosis, and you ought to be perfectly aware of this and never be ashamed of saying so. You ought always to say, when there is any doubt, that you must wait until the typical eruption appears before forming an opinion. After three or four days, if no eruption occurs, you can dismiss the diagnosis of small-pox.

Having considered the diagnosis during the initial stage, the next thing is to consider the diagnosis during the *eruptive stage*, and here you may have considerable difficulties. There are a number of different conditions which may be mistaken for small-pox during this stage. At the very commencement of the eruption, especially in cases of confluent small-pox, you may be doubtful for a short period whether you are dealing with small-pox or measles. In the early stage of confluent small-pox the eruption starts as maculæ, which do not become papular until after some hours. I remember a case of this nature that was taken into the London Fever Hospital. The patient was severely ill, with a high temperature, and an eruption which had just appeared, and it was a question whether that was a case of small-pox or a case of measles. We had to wait for some twelve hours before we could be quite sure.

You remember that in small-pox, with the onset of the eruption the temperature usually falls; and then you may mistake the papules for various other conditions. For instance, you may mistake them for acne, especially the form of acne which is called acne variolæ formis. But the history of the cases will decide the diagnosis. In acne the eruption has probably been out for some time, and there has not been any preceding constitutional disturbance.

Some forms of syphilis may be mistaken for the eruptive stage of small-pox, papular syphilides becoming vesicular and pustular, but a careful inquiry into the history of the case will render the diagnosis easy.

Iodides or bromides may produce an eruption very similar to that of small-pox.

Various forms of lichen, or even milaria, or eczema may be mistaken for small-pox eruption. You may think that any of these conditions ought easily to be distinguished, but they are not always easy to distinguish because cases of these different skin eruptions are frequently sent to the small-pox hospital diagnosed as small-pox.

Supposing that the temperature has not actually come down, you may mistake the disease for certain other fevers, as, for instance, glanders and varicella. Sometimes in glanders there may be an eruption which starts in a similar way to that of small-pox, as a papule, which, however, very quickly becomes pustular. But the pustule is usually much larger than that of small-pox and discharges blood-stained pus. There is not infrequently nasal discharge, and in addition to the pustules, subcutaneous abscesses in the muscles. I remember a case which came into Clinical concerning which there was doubt as

to whether it was a case of glanders or small-pox.

With regard to varicella, it may be perfectly easy to form a diagnosis, or it may be absolutely impossible. In varicella the eruption does not usually take the same distribution as in small-pox. In small-pox the eruption first affects the face and wrists, and then the rest of the body. In varicella the eruption specially occurs upon the trunk, more particularly upon the back, and very often hardly affects the face at all. Then, again, the eruption in varicella becomes vesicular within a few hours of its formation, and the vesicle very quickly becomes a pustule, a process which is quite different to the mode of the development of the pock of small-pox. It is perfectly easy to distinguish unmodified small-pox from varicella by the character of the eruption and by the distribution of the eruption; but where you are dealing with small-pox modified either by vaccination, or by previous attack, or by the fact that the patient is insusceptible, then the question is a very different one. In varicella the eruption comes out almost immediately after the patient feels ill; in small-pox there is almost invariably an initial stage. However, in some cases of modified small-pox that is not the case, and you get the eruption as one of the first signs of the disease.

There is another point. In varicella the eruption frequently comes at different periods in adjoining areas of skin. You do not get that in small-pox. Although in small-pox the face is first affected and the legs last, you do not get groups of papules coming out on the chest or face, or trunk, at different times.

Those are the principal ways to distinguish between variola and varicella. If you have any great difficulty in coming to a diagnosis, the best plan is to vaccinate the patient. If he is suffering from variola the vaccination will not take. A case has been known in which the patient was successfully vaccinated a day before the eruption of small-pox came out, but vaccination is not successful after the eruption of small-pox has appeared. Consequently you can use vaccination as a means of distinguishing between doubtful cases of small-pox and varicella.

Notes from Dr. Shaw's Out-Patients.

AMONGST the cases seen on Friday, February 7th, were the following:—

A cabman, about 50 years of age, who a few months previously, while suffering from his usual slight winter cough "brought up" over a pint of blood. Since then he has been "shaky" and had suffered sometimes from palpitation, but he was steadily improving and only came up to the hospital because his friends wanted him to.

Dr. Shaw invited the class to decide whether the blood was "coughed" up from the patient's stomach or lungs, classifying the means of differential diagnosis under the three headings—

(1) Conditions and admixture of the blood.
(2) The method of its "bringing up."
(3) The history of or presence in the patient of a cause of hæmoptysis or hæmatemesis.

Under heading (1) it was elicited that the patient remembered the blood to have been very dark and clotted but could not remember whether it was mixed with food or sputum. Under heading (2) the patient stated that he awoke with a sickly sensation in his throat, began to cough and feel sick, and the blood then "came up." The whole quantity was brought up within fifteen minutes and the patient felt quite certain that none whatever was brought up in the succeeding twenty-four hours. Under heading (3) the patient stated that he drank beer in the day time and spirits at night; that he could not claim to be an abstemious man, and that he was often sick before the occasion on which he brought up the blood. On examination his liver was found to be easily palpable, though not seriously enlarged or unduly hard. There was slight emphysema and no sign of phthisis. The diagnosis made was *hæmatemesis from cirrhosis of the liver.*

The next case was a bricklayer's labourer, about 27 years of age, who during the last winter had been unable to work on account of a feeling of weakness, occasional vomiting, and pain in the chest. He had been some weeks in an infirmary where he thought a diagnosis of heart disease and consumption was made. Since he had been out of the infirmary the most prominent symptom was a feeling of coldness. If he failed to keep his hands in his pockets his fingers would go quite numb and dead. He was certain that this had never happened to him in the winters preceding the present one. On uncovering his chest it was noticed that his nipples and axillæ were very dark. When asked if he had noticed any change in his colour, he said that when he came out of the infirmary his "pals" said that he looked so sunburnt that he must have been to South Africa. There were numerous small pigmented spots in many parts of his body, and the mucous membrane of his lips and inner surface of his cheeks were marked by large patches of pigment. A diagnosis of *Addison's disease* was made and the patient admitted to a general ward.

A man, aged 50, was sent up for a second opinion on account of a very chronic gastric trouble. He said that in the last fourteen years he did not believe he had had a fortnight free from pain after food, or vomiting. At the present time he had pain after every meal, which was only partially relieved by vomiting. He had always been thin but thought he was wasting rather more rapidly lately. He had never vomited blood or any black fluid.

On uncovering his abdomen the lower part was more prominent than the upper, and on auscultation and palpation it became evident that the stomach was enormously dilated, its greater curvature reaching almost to the pubes. Succussion was very marked, although it was more than six hours since the patient had taken food or drink. No peristalsis could be excited in the cardiac wall and no tumour felt at the pylorus. His teeth were very deficient. Dr. Shaw said he regarded the case as one of atonic dilatation without obstruction, and he thought the length of history satisfactory as making the case unlikely to be one of growth, but unsatisfactory so far as affecting a cure was concerned. These cases had been healed surgically by putting a pleat in the wall of the stomach; but as the trouble was not due to the size of the stomach, but to the atony and want of elasticity of its walls, improvement was surely in spite of and not in consequence of the treatment. It seemed more rational to completely empty the stomach every day by washing it out, and to avoid as far as possible any over-distension of it, which was of course not generally due to the volume of food taken, but to the large amount of gas generated by decomposition. Daily stomach washing, a rather dry and limited diet, with a pill containing Nux Vomica, Cascara Sagrada and Carbolic Acid, might in such cases have very good results. In order that the good should be in any way permanent it was most necessary that the patient's teeth should be dealt with. The diagnosis made was *non-obstructive gastric dilatation.*

A man, about 30, stated that he was quite well till ten weeks ago, when he had a sore throat. On recovery from this three weeks ago he went to a convalescent home, and there he caught cold, which he was unable to shake off owing to the bad food and uncomfortable quarters provided, as he stated, by the home. On examination he was constantly coughing, his cough evidently dislodging sputum, which he swallowed; he was greatly emaciated and one side of his chest was sunken in and almost immobile. He could not be made to admit that he was in any way ill when he went to the convalescent home, notwithstanding that the physical signs clearly indicated phthisis of long duration. Dr. Shaw said he recognised this temperament as common in phthisis, and a temperament quite different to that shown by the subjects of spes phthisica. The patient seems to have a morbid sensitiveness about having consumption as if it was in some way a disgrace. Such cases seemed to be on the increase, no doubt as a result of the crusade against tubercle, which, unless carefully managed, would mean a great deal of hardship to the subjects of the disease. The educated people learnt from the pamphlets and tracts so freely distributed the fact that a consumptive was dangerous to the community, without caring how the danger ought to be averted. The life of a consumptive surrounded by neighbours of this sort is anything but a happy one. Diagnosis, *advanced pulmonary tuberculosis.*

A youth, aged 24, a sawyer, came complaining of an almost constant headache for three months. The only other symptoms he noticed were that when the head was very bad he was sometimes sick and that lately the sight of his left eye had become blurred. After a bad attack of retching he thought his face sometimes was swollen. On examining his heart there was noticed to be a very accentuated second sound in the aortic area. His pulse was high tension and his artery thickened and tortuous. The cause of his deficient sight was next investigated, and he was found to have very extensive optic neuritis with hæmorrhages and white patches in the retinæ. There was a distinct ring of albumen on pouring the urine on to concentrated nitric acid. The case was admitted to the ward as one of *chronic interstitial nephritis, arterio-sclerosis, albuminuric retinitis.*

Among the women there was a case of mitral stenosis with advanced pregnancy, and another was a woman 45 years of age whose last child was five years old. A month ago, after some slight pain and discomfort in the abdomen she became jaundiced and had remained so without intermission since. On examination, she was deeply jaundiced all over and the edge of the liver was felt below the umbilicus. On the anterior surface of the right lobe of the liver there was a large rounded prominence, at the apex of which was a small nodule. There was no umbilication. Diagnosis, *carcinoma of the liver.*

The Lepers' Home at Spanish Town.

ON New Year's day, 1902, whilst conducting a Mission at Spanish Town—or S. Jago de la Vega, the old capital of Jamaica—I paid a visit to the Lepers' Home, and gave an address to the inmates. The Home is situated about a mile from the town, on low-lying land away from other habitations; it occupies some 20 or 25 acres of land surrounded by a wire fence. After a little talk with the Medical Officer, Mr. W. D. Neish, M.D., and the resident Superintendent, Mr. Levy, we went to the little chapel, which was filled with nearly a hundred lepers—male and female in about equal numbers—young and old, some, of course, frightfully disfigured, but others with hardly a sign of disease visible on their faces. I was surprised to find, however, that the "leper as white as snow" was conspicuous by his absence, though I am told that this type of leprosy is to be found in the island. Naturally, it was in some ways trying; the odour from so large a number in close contact was strong, and in the hymns their voices were harsh and jangling almost

beyond belief, whereas an ordinary coloured congregation sings with taste as well as great vigour and harmony.

After the service, Dr. Neish took me over the Home, first over the women's quarters, and then over the men's; to the infirmary, dormitories, and living and recreation rooms in each case, and afterwards to the farm. The buildings are raised on poles above the ground in regular West Indian style, and are spotlessly clean and neat; very simple, of course, but with a care for harmony of colour so pleasing to the eye. The lepers themselves do the painting, whitewashing and repairing of woodwork; whilst on the farm they grow plantains, bananas, yams, and indeed a good deal of the vegetables and some of the fruit used in the Home. For these the workers are paid, the proceeds serving to procure the little articles of showy attire, of which the negroes and coloured folk (in the West Indies the latter name is rigidly kept for those of mixed race) are so fond, and as it was a holiday, I could see the result, now in a showy handkerchief, now in a resplendent pair of braces, now in a stiff white shirt which harmonized strangely with the rest of the attire. Of course all necessities are provided, including a yard of tobacco a week for the men. In fact, in Dr. Neish's words, "the Home is not a penal settlement, but an institution where every effort is made to alleviate the disease."

As I have said, one does not need to look far to see that this is done. The patients were full of interest in all that went on, and were eager to show me what they thought would interest me—their recreation room, the tree which was planted in memory of Queen Victoria at the time of her death, and so on. Naturally, however, the patients themselves were the most interesting of all. Here was a good-looking young child, a mulatto I should think, with nothing to distinguish her outwardly from any similar child in Kingston or Spanish Town, excepting a slight hardened swelling on the cheek; she seems to be improving not a little, according to Dr. Neish's report, under the treatment by subcutaneous injection of anti-streptococcic serum, obtained from the Lyons Institute. Here was a boy, of Spanish parentage on one side, with no greater sign of the disease; he speaks no Spanish, though another patient, who has worked on the Spanish main is voluble in the harshest South American jargon. In the infirmaries patients were lying comatose and bloodless, perhaps dying from diseases other than leprosy itself. On the other hand, the oldest inhabitant of the Home is a cheerful shrivelled little woman, who has been there since in 1876, having previously been for seven years, if I remember rightly, in a former home in the Healthshire Hills; whilst the most interesting case of all is that of an old woman, Martha, who does not know her age. She was once a slave, has been a leper for over fifty years, and although without feet or hands, is very bright. According to Dr. Neish, indeed, leprosy would seem to be a cure for almost every bad habit and every evil humour. His leper patients, he says, are cheerful, peaceable, and industrious. And although we learn by degree that this view is in part the result of the allowances which he makes for their affliction, and that they are liable to occasional outbreaks of temper, irritation, and despair, like the rest of this race of warm-hearted overgrown children, it is clear that the love and care which are so freely bestowed upon them are by no means without their reward.

From the last annual report on the Institution made by my friend, Dr. Neish, and published in a supplement to the official *Jamaica Gazette* for December 19th, 1901, I take the following facts. There were 123 inmates of the Home (some being suspect cases) on March 31st, 1901, the number having diminished slightly for several years. The cost of their maintenance, as Dr. Neish informs me, was 11·1 pence per head per day; whereas that of lunatics was 11·25 pence. And as, since the Law 17 of 1879 was passed all indigent lepers are to be taken into the Home, he thinks that this decrease of admissions probably represents a decrease in the number of lepers in the island. It is, of course, possible that some cases are concealed by friends, but from the evidence at his disposal he does not hold the opinion that this is so to any great extent. The two varieties of the disease, tubercular and anæsthetic leprosy, are about equally represented. Dr. Neish has already made bacteriological researches in connection with both forms, which are summarised in this report; he hopes to do more as the laboratory equipment at his disposal becomes more adequate, and I believe that he proposes to visit England this year to go through a course of bacteriological study. As to treatment, Dr. Neish says "there is no doubt in my mind that so far, the subcutaneous injection of a soluble salt of mercury is the most efficacious method of treatment." He has, however, used injections of antistreptococcic serum, especially in the case of the little girl above referred to; and he hopes to do so with more success with a more active serum obtained by a cultivation of the *bacillus prodigiosus*, and used with good results at Molokai, since that obtained from Lyons was frequently inert and useless by the time it reached him. He has also used a subcutaneous injection of 5 cc. of sterilized Chaulmoogra Oil, whatever that may be, with good effect.

This last paragraph must not be considered an adequate summary of the medical portion of the report, but perhaps I have exposed my ignorance enough, and therefore will stop.

W. E. COLLINS.

Papers by Guy's Men.

Medical Education in Italy. By F. H. Burton Brown, M.A., M.B., Physician to British Embassy, Rome.—*British Medical Journal*, 30th November and 14th December, 1901.

A brief note on the use of Petroleum Emulsion as an intestinal drug. By Theodore Fisher, M.D., M.R.C.P. Lond.—*The Lancet*, 1st February.

A Punch and Judy Show, or a Stray "Companion."

(With apologies to the shade of Leigh Hunt).

By HAMILTON LAVERS-SMITH.

OF all the open-air attractions provided for the youth of this metropolis (and we could wish in the interests of health they were more in number) there is none which affords us more genuine entertainment than the time-honoured Punch and Judy Show. Whether this is attributable to our well known taste for theatricals, or love of fresh air, or to the pleasure communicated by the sight of so many happy young faces, we have never been very solicitous to discover. If cross-examined by a casual acquaintance, we could furnish a score of good and sufficient reasons highly flattering to our respectability and taste; but with the gentle reader, our intimate and "Companion," already acquainted with most of our foibles, our practice is to be confidential and self-revealing at all hazards. In confidence, then, it must be conceded that these are not the primary causes. Regarded as a drama, the show has many manifest failings, leaving much to be desired, and cannot with any truth be described, in the language of Hamlet, as "an excellent play, well digested in the scenes; set down with as much modesty as cunning." Nor is our partiality for fresh air more than a secondary cause. Idling in the open air is better than staying indoors, but the atmosphere of a crowded thoroughfare bears no comparison with the breezes of Hampstead Heath, or some other "Northern Height," the praises of which are sung by Mr. Howitt. The smiling faces of children assuredly are not to be denied; but the chief attraction has yet to be named, and not to keep the reader longer in suspense, we will confess at once (damaging as the admission may be) that it arises from a most ill-placed affection for that shameless rascal, Mr. Punch himself! Enquiries of this sort, when honestly conducted, are so often productive of disappointment, that they are best avoided if we are to preserve a passable opinion of ourselves. To express any sympathy with such a hopeless and determined scoundrel as Punch demands a degree of candour on our part which almost amounts to recklessness. When we consider all his odious qualities, his depravity of manner, his brutal treatment of Judy, his wanton cruelty, and his open defiance of the law, the catalogue of his offences must surely stagger his least scrupulous supporter, and leaves us amazed at the fidelity of even dog Toby.

How are we to explain the extraordinary popularity of Punch? Mr. Hazlitt, in course of his lectures on the English Comic Writers, tells us of one who declared that "he liked a comedy better than a tragedy, a farce better than a comedy, a pantomime better than a farce, but a puppet-show best of all." He must have been a merry gentleman, and we envy him his candour.

There is something fascinating about a career of bold and reckless villany, always providing it is attended with success, and plentifully decorated with gold lace. Witness the popularity of Jack Sheppard, Claude Duval, and a host of minor delinquents who make such figures on our melodramatic boards. The more law abiding and peaceably disposed we are the better we appreciate the contrast. A very dear friend and contemporary essayist, who loves to masquerade in wolf's clothing—though his disposition and very name proclaim him another quadruped—is a standing example. Does not the gentle Elia fearlessly affirm that he can even take delight in the heartless and dissolute heroes of Wicherley and Congreve; considering them as the puppets of the hour, the inhabitants of a fanciful bedizened region removed from the restrictions of virtuous behaviour? Punch is one of these. He carries us by storm. To differ from him is to be derided; to reprove, is to be struck over the head. We have no mind to question the morals of a ruffian whose sole argument is a stout cudgel. Those who have once heard the resounding strokes of Punch's baton on the wooden carcasses of his victims are more disposed to be differential than didactic. The bare recollection chills us to the marrow!

Who that cherishes the memory of his childish days can forget the monotonous but bewitching strains of the pan-pipes, summoning their juvenile auditory to a distant square, or better still, inviting him to the "yellow sands" of some seaport town? Can he recall how unhesitatingly he evacuated the sandy fortifications defended with so much gallantry all the morning, and joined the attacking party in one wild race for the best coin of vantage; how unceremoniously he wedged his way through the crowd, deftly insinuating his small person between the petticoats of nursemaids, and the legs of policemen, until he had reached the coveted position of a front stall; then how provokingly the stall-holders trespassed on the open space so jealously guarded by the gentleman who performed on the pan-pipes, and how, in the intervals of the said pan-pipes, in order to stimulate the expectancy of the assembled crowd, the familiar voice of Mr. Punch was heard caroling a jovial ditty from the lower stories of his turret? The anxiety and suspense of the audience, awaiting the entrée of Punch, and eager to applaud him in all his criminal encounters, was the same a century ago; and Dean Swift has depicted the scene in his liveliest colours:—

"Observe, the Audience is in Pain,
While Punch is hid behind the scene;
But when they hear his rusty voice,
With what Impatience they rejoice!
And then they value not two straws
How Solomon decides the cause,
Which the true Mother; which Pretender;
Nor listen to the Witch of Endor;
Shou'd Faustus, with the Devil behind him,
Enter the stage, they never mind him;
If Punch, to spur their Fancy, shows
In at the Door his monstrous Nose,
Then sudden draws it back again;
O, what a Pleasure mixt with Pain!

You ev'ry Moment think an age,
'Till he appears upon the stage;
. . . .

He gets a thousand Thumps and Kicks,
Yet cannot leave his roguish tricks;
In every action thrusts his Nose,
The reason why, no Mortal knows;
. . . .

There's not a Puppet made of Wood,
But what wou'd hang him, if they cou'd;
While teazing all, by all he's teaz'd,
How well are the Spectators pleas'd!
Who in the Motion have no share,
But purely come to hear and stare;
Have no concern for Sabra's sake,
Which gets the better, Saint or Snake,
Provided Punch (for there's the Jest)
Be soundly mawl'd, and plague the rest?"

What need to recapitulate the leading incidents of the drama? If we were to express a preference, it would certainly be in favour of the crowning scene where Punch, having run his criminal course, is at length to meet with his deserts. The law's delays are proverbial; but when a man has depopulated a parish, and littered his parlour with dead carcasses, it is time for justice to be stirring. Who does not admire the exquisite ease with which the stage difficulties are overcome at this crisis of the play? A less skilful dramatist, conscious of his critics in the front row of the pit, would have conceived no alternative but a complete change of scene, and we can imagine the plentitude of his stage directions. Act V., scene 4. A "Carpenter's scene" set in foreground, representing a dark cell of Newgate Prison; walls hung with sundry instruments of torture (the note of exaggeration is not amiss!) one small grated window, and heavily barred door at rear. Punch discovered, attired in prison dress, seated on wooden bench, and loaded with chains. Prison bell solemnly tolling without. Enter Chaplain and Jailer, announcing moment of execution. Scene shifts, discovering Court Yard, with Gallows. Procession files in, disposed as follows, etc., etc. Do we find the play impeded with such elaborate instructions? Not a whit—the hangman--enters, with the same inconsequence as the milkman. The gallows are erected with such business-like and alarming rapidity, we feel annoyed at the man's want of decent compassion. What! No Warrant of Arrest? No trial and sentence of the Court? No proper interval for repentance and composure? Our sympathies are certainly with Punch; and not a man or child in the audience but what would rush to the rescue were it not for the austerity of the gentleman, whose astonishing facility on the pan-pipes delighted us a quarter of an hour ago, and who now reclines with provoking apathy against the walls of Punch's turret, smoking a pipe of tobacco as refreshment, after levying his final contributions of coppers. Meantime, Punch is apparently in an agony of suspense, shaking like an aspen leaf, and bewailing his fate in accents which seem to betoken excessive emotion. The remorseless hangman adjusts the noose, and all is in readiness. Is there no reprieve or way of escape? Apparently none. Punch mounts the scaffold with faltering steps. The situation is intense. Nothing remains but for the prisoner to insert his head in the noose, and all will be over. But this simple proceeding presents an unforeseen difficulty, and gives rise to discussion. Some defect of vision, not hitherto discoverable, renders it impossible for Punch to hit off the aperture. First he darts his head to one side, then to the other, till the hangman's patience is fairly exhausted. With the best disposition in the world to be hanged, the task is beyond him. Will the gentleman oblige by giving a practical demonstration? Certainly, it's the easiest matter conceivable; astonishing what difficulties people will raise over a little matter of this kind. So! Punch dallies with the free end of the rope, and keeps up a running fire of interrogations. "Is the perch comfortable?" The executioner pronounces it not only easy, but positively luxurious. "Will the rope bear?" The exasperated officer consigns himself to everlasting perdition, if it would not swing an ox, and is instant in his demands to be let out. We know the conclusion. With a sharp snap Punch pulls at the rope, the fatal noose tightens round the neck of his unfortunate victim, whose screams for mercy are met with shouts of derisive laughter on all sides, and the man of law dies the dupe of his own simplicity, and a martyr to his own profession. To laugh on the occasion is instictive and irresistible, and we have the authority of Mr. Lamb that no moral harm ensues from it. Punch is like the Mirabels and Dorimants of artificial comedy, who, as that delightful essayist tells us, "break through no laws or conscientious restraints," because "they know of none."* A child who applauds is no more in danger of stabbing his brother in a dark corner of his nursery, than the spectator at a pantomime is tempted to emulate the clown by stealing a string of sausages from a pork butcher's shop.

If ever the family history of Punch is published for the gratification of his many admirers, we shall be surprised to find what a long line of ancestors he can boast of. It has been stated that movable figures have been found in ancient Egyptian tombs, which may have served as toys for the juvenile subjects of the Pharaohs, and had we time to pursue the enquiry, perhaps it would be no impossible task to furnish a pedigree commencing with "the creation of the world" and "Noah's Flood."

It is certain at least that Mr. Robert Powel, that prince of puppet showmen, thought it no violation of

*It is curious that two such original thinkers as Charles Lamb and Hazlitt should both take the same view of this question. They appear to have assumed every playgoer to be on the same intellectual plane, and capable of making like mental distinctions as themselves; but in point of fact such is not the case, Those who have had the curiosity to follow the controversy which originated with Jeremy Collier's "Short View," are generally of opinion that his opponents were defending a bad cause. The discussion is now of only theoretical interest, as a paternal government leaves little scope for the exercise of discretion.

"the unities" to introduce Punch and his spouse performing a dance in the ark when he delighted his audience with a faithful representation of those stirring times. Granted that Mr. Isaac Bickerstaff, in noticing one of these performances appears to throw some discredit on the show on this very account, but then he must be poking his fun at everything, and as Dryden, no mean judge of the drama, has sung:—

"He who servilely creeps after sense
Is safe—but ne'er will reach an excellence."

Words surely of such liberal encouragement as to justify far greater breaches of dramatic rules.

We can well imagine the incongruous association of Punch and the Patriarchs on the same stage must have furnished a rude shock to the fastidious taste of the professed critics of the day, nor is it surprising to find that Addison, who has devoted a Latin exercise in verse to the description of the puppet-show, cannot brook the intrusion of Punch on these solemn occasions:—

"E'en when some serious Action is display'd
And solemn Pomps in long Procession made,
He, uncontrollable, of Humour rude,
Must with unseasonable Mirth intrude:
Scornful he grins upon their Tragic Rage
And disconcerts the Fable of the Stage."

The frequency with which the puppet-showmen resorted to scriptural stories for the groundwork of their plays is perhaps to be explained by their anxiety to cater for squeamish tastes, and encourage parents to bring their offspring. The immortal Isaac Bickerstaff records that although some of the critics took exception to Mr. Punch jesting during the Deluge, Mrs. Petulant thought it a very proper play for young people, and desired both her daughters "to mind the moral."

From other sources, however, we gather that some of the subjects selected were not at all adapted to the infant mind, and if Steele's humorous advertisement of a piece entitled the "Chaste Susannah," with the specious announcement of the first appearance of "Two New Elders," was suggested by an actual bill of play, we can well imagine the entertainment was no food for babes.

It would be interesting to ascertain from what source Mr. Punch acquired his traditional deformities of person. Addison's description, which was penned in 1699, is well recognisable, and would stand good at this day:—

"But one above the rest distinguished stalks;
A Hero, who in hoarser Accents talks.
Large is the Buckle that his Vest controls;
His Mimic Eye with living Motion rowls.
His Belly turgid of enormous size;
Behind a Back a Bulk of Mountain lies."

Ned Ward, whose "London Spy" made its appearance a few years earlier, has a similar reference to Punch's husky voice, and lets his readers into the secret that it was conveyed through the medium of a "tin squeaker." But these minute confidences are distasteful. The infantile mind rightly rejects such disillusionments, and refuses to entertain a suspicion of Punch's actuality. The evidence is too convincing to the contrary, and has even overpowered full grown bumpkins. That pleasant gossip, Anthony Aston, relates a story about Betterton taking one of his country tenants to witness a puppet show at Bartholomew Fair, when "Roger was enormously diverted with Punch [we love him the better for it] and bred a great noise, saying, that he would drink with him, for he was a merry fellow," and when the deception was explained it was all to no purpose, and he insisted on leaving sixpence for Punch to drink his health. Was this the historic occasion on which the showman of the booth refused to accept an entrance fee from the great actor on the astounding ground that they were brother artists? Those with a better memory for theatrical traditions can perhaps inform us.

But we digress, and grow garrulous in the praises of Punch. With reluctance we must take leave of so entertaining a companion. Farewell, thou piece of Pinchbeck anatomy! Most valiant man of straw! Never do we catch a passing glimpse of thy wooden castle, and hear the familiar "rusty" voice of its lord and master, but we are instantly impelled to mingle once more in the crowd of cherub faces, and join in the plaudits of all thy apish tricks.

Charles Murchison Scholarship in Clinical Medicine.

The next Examination for this Scholarship will be held at the Royal College of Physicians of London, on Monday, the 7th day of April, 1902, and following days.

The Scholarship is open to any Student of Medicine who has been a registered Medical Student during a period of not less than five, and not more than seven years at a Hospital in London or Edinburgh, recognized by the Royal College of Physicians of London or by the Medical Faculty of the University of Edinburgh, and whether holding a Medical qualification or not.

The Examination will be conducted both orally and in writing, and will include—

(*a*) Examination of Patients, with reports on their cases.

(*b*) Questions on Pathology and Treatment, and

(*c*) Examination on Specimens.

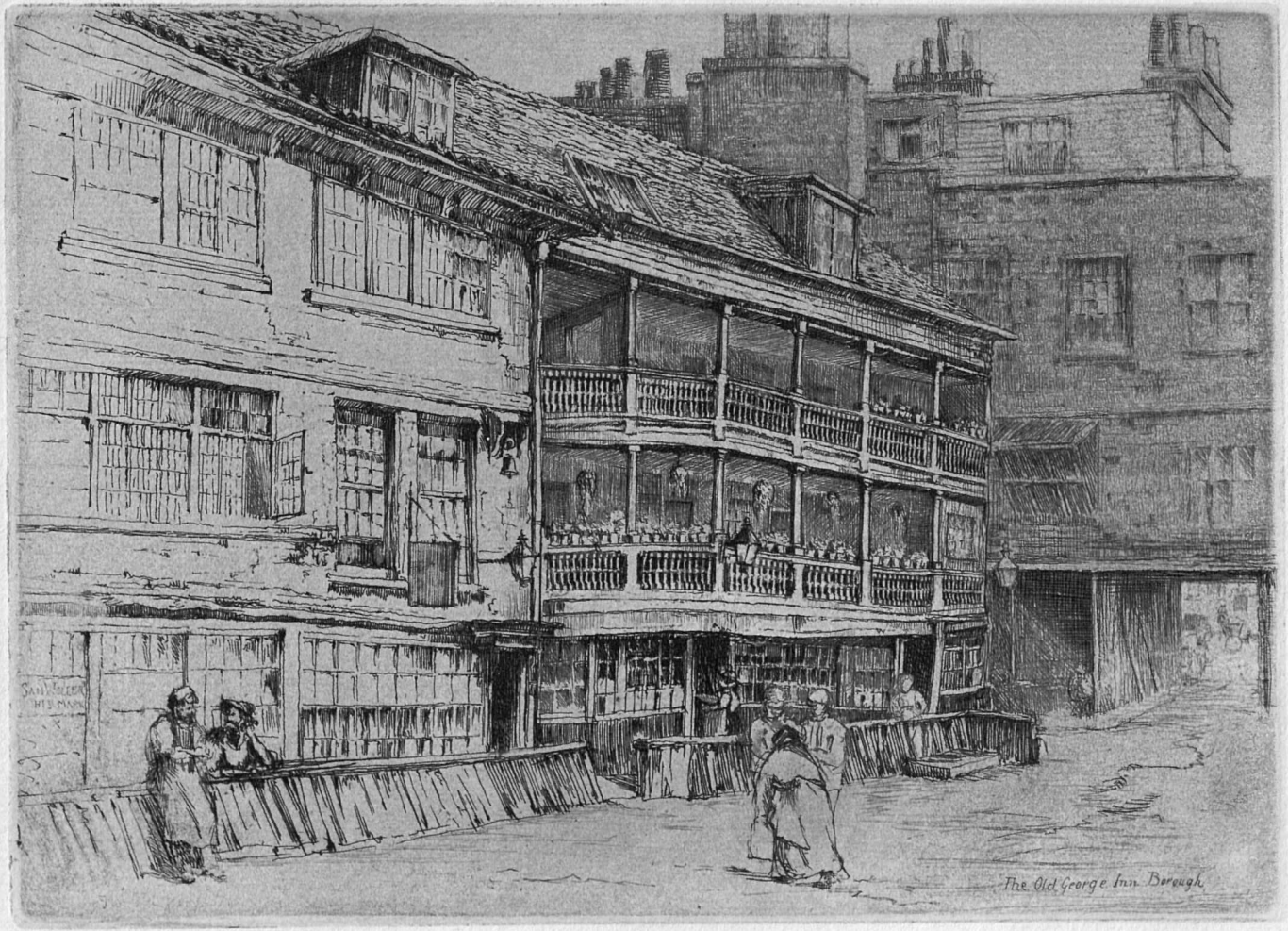
The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than March 25th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

(The Examination for 1903 will be held in the University of Edinburgh.)

EDWARD LIVEING, M.D., Registrar.

Royal College of Physicians, London,
January, 1902.


The Old George Inn Borough

Passim.

"Hail Bishop Valentine, whose day this is,
All the air is thy diocese,
And all the chirping choristers
And other birds are thy parishioners."

We have received a small brochure dealing with the newly constituted West African Medical Staff. The former colonial services of Lagos, Sierra Leone, the Gambia, the Gold Coast, and Northern and Southern Nigeria are now amalgamated in this new staff service. It is hoped, we suppose, that the service will prove more attractive to the young and desirable practitioner than has been the case under the old régime. It does not require a very extensive examination of the Colonial Office's project to see that the old principle of getting something for nothing is still kept prominently in mind, even in the light of recent developments. No one needs to be told that the climate of the West Coast is not that of a health resort, nor is it necessary to emphasize the sound principle that the greater the risk, the greater must be the recompense. When, therefore, the salary scheme is considered, the utter inadequacy of the service is at once apparent. The first stage, that of medical officer, carries with it a stipend of £400 a year; the highest is rated at £1,000, with an annual increment of £50, until £1,200 is reached. And this applies only to the colonies of Nigeria and the Gold Coast. For some reason, probably connected with the internal finances of those colonies, the P.M.O. in Lagos and Sierra Leone is only rated at £800, rising to £1,000. We were unaware that the climatic conditions of these two last were superior to the rest of West Africa, or that the social conditions of life made eight hundred a year at Freetown, equivalent to a thousand at Accra. The balance of evidence, if such were taken, would certainly be in favour of the Gold Coast, as opposed to either Sierra Leone or Lagos.

The pension scheme, of little moment it is true, is niggardly almost to the verge of brutality. After eighteen years of Coast life, with twelve actually on the Coast, a Principal Medical Officer may retire, should he exist, on the fine salary of £540 for the Gold Coast, etc., and £450 for the Lagos and Sierra Leone colonies. Considering the number of men who claim, and ever will claim a pension, it would not be a very serious outlay if the Colonial Office retired them on full pay. The idea, phantom though it be, would certainly serve as an inducement to the man who was wavering, although it might serve also to impress upon his mind more forcibly the kind of country in which he was doomed to live. The Colonial Office cannot afford to be cheeseparing in the matter of pay. A very ordinary salary for a Medical Officer of a mine in the Gold Coast is £40 a month, with all found. The importance of this last addition may be realised when it is considered that the cost of food, etc., exported from England works out even in quantity to about £3 a week per man, not including cost of shipping. Tobacco and drinks have also to be considered. The mines, it is true, do not pay their men during leave, but they do not hamper nor stint them when they are actually on service. One mine, at least, gave its medical officer £800 a year, in addition to food and tobacco.

But it is in the consideration of the minor details that the insufficiency of the scheme becomes most apparent. For instance, clause (b) in the section on allowances provides that 2s. 6d. a day will be paid to the M.O. on duty at his station for any periods during which he was required by Government to keep, and has actually kept a horse, carriers, etc., for the purpose of personal conveyance. There are few places on the Coast where horses can live, and then the life of a horse is reckoned only in months. This reduces the means of conveyance, for anything but the actual town where a rickshaw can be used, to a hammock. Now a hammock has a complement of eight "boys" and no one is more punctilious in this respect than the hammock-boy. Taking the cheapest rates—and the influx of Europeans through the gold boom has considerably advanced prices—a hammock-boy receives 1s. 6d. a day and 3d. subsistence money. This, for the crew, works out

at 14s. a day, and the Government allows 2s. 6d. When employed in the field or bush, away from recognised stations, an officer may draw an additional 5s. a day, but since his food and belongings must necessarily be carried by servants whenever he moves, his out-of-pocket expenses will be increased to a much greater extent than his pay. Private practice is allowed under certain restrictions, and when enjoyed this will without doubt materially increase the M.O.'s pay. The pamphlet does not see fit to point out, however, that it is in only a very few stations that there is anything to privately practice upon, and that even then the M.O. has to compete with the unofficial practitioner and also with the P.M.O. on that station—for it may be taken as an axiom that if a place is big enough to afford a private practice, it is big enough to require a P.M.O.—but we have said enough to enable men to draw their own conclusions as to the value of the West African Medical Staff.

THE kindness of Mrs. Poole has enabled us to publish with this number a most excellent photograph of Wordsworth Poole, taken whilst in Pekin. Since the obituary notice which appeared in our last issue was written, we have heard from one of the first sisters to help in the experiment of introducing English nurses into Central Africa. Whilst out there she was greatly impressed with Wordsworth Poole's untiring energy, realising the fact that men cut off from all civilisation needed plenty of healthy interests, he set to work and inaugurated a sports club, laid the tennis courts himself with native help, and was captain of the football team, in fact he started a new and wholesome era. Undoubtedly his personal charm enabled him to succeed where many another man would have failed. This is indeed another striking example of the man's sterling worth.

WE do not think there will be any two opinions among our Subscribers as to the excellence of the work of the Artist to whom we are indebted for the etching. Miss Constance Pott will be remembered by her renowned picture of the front quadrangle of the Hospital, issued through the Gazette in 1896. As a member of a famous old Southwark family it is a labour of love for Miss Pott to revisit and find her work among familiar scenes. We may mention that 100 proof copies of the "George" have been printed on Japanese vellum and signed by the Artist. These may be obtained from the Librarian at the price of half-a-guinea, by post eleven shillings. Having regard to the fact that what remains of the "George" is the last bit of the old Borough inns, and may itself disappear almost at any time, the possession of one of these proofs is a thing to be desired.

THE "Old George" is one of the finest of the inns that have become famous in fiction. It is generally accepted, although it cannot be definitely settled, that the genial Sam Weller hailed from this old hostelry in the time when, as can be seen from an old time-card that is preserved, no less than eight different coaches started each day from its doors. The picture which appears as our supplement shews the existing portion of the building, but at one time it surrounded the court-yard, and the part which was demolished twelve years ago had galleries similar to the present. Entering the door in the middle one is at the foot of the staircase that leads up to the balconies. On the right is a fine old bar, where even Mr. Willett, senr. might have felt at home, and opposite it is an old-time coffee room with its dark mahogany tables and wooden partitions. The sitting and bed-rooms upstairs open on to the balconies, and the quaint furniture, solid four-poster beds, old candlesticks and extinguishers, and the leaded windows, bring back to us forcibly the vivid descriptions of Dickens. The old inn, dating back to the fifteenth century, has had Mrs. Murray for proprietress for nearly twenty-two years. Although it is so close to us very few know it, and we can safely say that a visit to such an interesting spot would be well repaid.

IN our first match in the Rugby Cup-ties of the present year, we met St. Bartholomew's, who were probably our most dangerous opponents, and defeated them by a goal and a try at

Richmond, on Tuesday, Feb. 4th. Influenza had somewhat weakened our team, as Anderson had to stand down from the forward line, and two others had not really recovered. It was a really hard game, and it was only by sterling tackling that we won the victory. In the pack our forwards were beaten, although working hard, but they showed up well in the loose. The opposing forwards were exceptionally strong and made excellent rushes, which were, however, to a large extent frustrated by the brilliant play of our halves, particularly Payne. Outside we were much the better side. The passing was not quite up to our best standard, but the tackling was splendid, McEvedy perhaps being the most conspicuous. Morgan on the one wing had little to do and was very carefully watched, but put in one or two fine runs, one just before time being very smart. Alcock played one of his characteristic games and scored both of our tries in spite of considerable opposition. O'Brien made a fine attempt to drop a goal, only just failing from about forty yards distance.

The *Lancaster Guardian* for January 25th, records the death of an old Guy's man, Surgeon-Major Metcalfe Johnson, J.P. He was a student at this hospital in 1843. After various appointments he became associated with the Royal Lancaster Regiment, and was made Surgeon-Major in 1873. He seems to have been extremely popular with the soldiers, who familiarly called him "Old Iodine," on account of his fondness for using this drug. The following characteristic story shows that he had but scant regard for militarism. "There was a full dress parade, and unfortunately it was raining. Mr. Johnson had to attend. He made his appearance in full dress uniform, plumed hat and overcoat, but carrying an umbrella. This, however, was not all. His trousers not having been strapped, had got hitched up, displaying his bright red stockings and spurs dragging after a pair of low shoes. When he got to be surgeon-major the guard had to turn out when he made his appearance, and his customary method of returning the salute was a vigorous wave of his pipe."

The latest volume of the Hospital Reports, published this week, is quite a notable number, the first thing that strikes the eye is the lavish liberality in plates and tables—though the size and complex nature of the latter may sometimes damp the interest of the man who reads casually with his feet on the mantelpiece—their use to the earnest seeker after fact cannot be over estimated. There is a greater variety in the articles. No longer are surgical papers conspicuous by their absence. We are especially pleased to see a paper by one of the former editors. Dr. Bryant and Mr. Steward cannot be too heartily congratulated on this last success of their co-editorship.

The Dinner of the Dental Society at the Hotel Cecil on Saturday, February 7th, an account of which we publish in our present issue, was a great success, as is always the case. A large number, close upon 140 being present, including many members of the Staff of the hospital, and a large sprinkling of old Guy's men. The after dinner speeches were extremely good, and the speakers for the most part adopted the light and witty style so suited to such an occasion, with excellent results. It is difficult to award the palm to any particular speaker, the stories of several were extremely good, especially that of Dr. Shaw, concerning the old time custom adopted at the Resident's table during his time of office, in thanking the President for the fare. A most enjoyable evening terminated by singing the national anthem, followed by an exciting struggle for coats in the cloak room.

At the last meeting of the Gazette Committee the subject of the Memorial to our men who have fallen in South Africa was fully discussed. The various schemes suggested by different contributors were fully dealt with, and although nothing can be announced at present, the Committee have a definite plan in their minds which will be executed when sufficient funds are forthcoming.

Considerable interest is being aroused in India on the subject of the prevention of Malaria.

Quite recently a conference was held at Naypur to discuss this question. Amongst those selected to attend were three Guy's men, Col. MacKay (for Central Province), Capt. Childe (Bombay), and Capt. G. T. Birdwood, whose paper on "Some Practical Suggestions for the Prevention of Malarial Fevers," formed the basis for a set of rules which was drawn up for the guidance of private persons, municipalities, and cantonments, in this matter.

A Smoking Concert is to be held to-night in the Dining Room of the College at eight o'clock, and Messrs. Holmes and Parrott, who have arranged the programme, promise a very good evening's entertainment. The last "Smoker" was so successful, that it has been decided to again rely on local talent. We hear that several new stars have been discovered, while many old favourites will shine as in the past. It is proposed to devote any surplus to the South African Memorial Fund.

The Association team did well in beating Ewell on their own ground by three goals to nil. It is, we believe, the first time for some years that we have beaten them. Barber scored all our goals.

Last Tuesday we were to have played Bart.'s in the second round of the Association Cup Ties but the ground at Chiswick was too hard and the game had to be postponed.

On Wednesday evening our chess team played St. George's for the competition for the shield, but were unfortunately beaten by $3\frac{1}{2}$ games to $2\frac{1}{2}$.

The First XV. made a poor show against Kensington although beating them by 15 points to nil. There was a considerable amount of vigor shown but scientific play was mostly missing, partly accounted for by the absence of several of our regular team. To-day we are due to play Lennox on their own ground.

Mr. A. C. H. Gray has been very unfortunate and is now in Clinical recovering, we are happy to say, from pneumonia. He has been obliged to relinquish his duties as A.H.S. in the Front Surgery, and Mr. A. H. E. Wall has been elected in his place. To him we offer our sincerest congratulations on his appointment.

On Feb. 4th the Worshipful Company of Barbers entertained Mr. Howse at a dinner. Dr. John Tanner, the Master, occupied the chair. Many excellent speeches were made and a most successful evening passed.

In a recent number we reminded our readers that the subscription of twelve shillings and sixpence to the Clubs' Union for Gazette and Reports was now due. Up to the present only a few have been paid, but we feel sure men have only to understand that a prompt payment to Mr. S. H. Croucher, at the Medical School Office, obviates the trouble and expense of sending out individual notices to insure a general response.

A Shield of the Guy's Coat of Arms has just been been produced. It is hand-painted in oils and gold leaf on solid metal, and is a careful copy of the original design supplied by the College of Arms. The size of the shield is $4\frac{3}{4} \times 3\frac{3}{4}$in. mounted on shaped oak block $7\frac{1}{2} \times 6\frac{1}{4}$in. Altogether it makes a most suitable decoration either for a library or a consulting room. It may be obtained from the Art "Relievo" Association, 34, Paternoster Row, or from the Librarian, price One Guinea.

The next examination for the Charles Murchison Scholarship in Clinical Medicine, will be held at the Royal College of Surgeons of London, on Monday, April 7th. Full details may be seen on the notice board in the colonnade.

As asepsis is of such vital interest in present day surgery, we are publishing an extract from *International Clinics* on the cleaning of hands—

"Surgically clean hands are unobtainable when a subungual space is allowed to remain. Essential to the practitioner's daily toilet are careful trimming and filing of the nails that leave no vestage of a subungual space, which, despite most arduous scrubbing and scraping, may yet remain a very hotbed for bacterial propagation. The little dermal elevations about the finger-tips, called

"hang-nails," and the integumentary folds at the bases of the nails must also be trimmed, to offer no recesses for the proliferation of infectious material. Many excellent treatises and monographs have been published on hand-disinfection. For practical purposes their gist may be summed up as follows:—

1. With a clean nail-brush vigorously scrub the hands for three minutes with soap in running water as hot as can be borne.
2. Rub the hands with pledgets of sterile cotton soaked in ether.
3. Rinse the hands with alcohol.
4. Crush wet crystals or tablets of potassium permanganate with the hands, and rub the resulting moist powder into the skin until it is of a dark mahogany colour.
5. Remove the permanganate stain by rubbing with crystals of oxalic acid in flowing hot water.
6. Rinse the hands with alcohol.
7. Rinse with sterile water.

These seven steps of hand-sterilization can be accomplished in about five minutes."

Tempora Acta.

By the departure of Dr. A. J. Cleveland the stage of our self-contained "Comédie Humaine" at Guy's is bereft of the last, but by no means the least, of a little company of men who made a very distinct mark upon the last hospital generation, for with him the sole survivor of the staff of the *Guyoscope* vanishes.

Therefore, the curtain down and all the actors off the stage, it may not be out of place to consider briefly what sort of part these men have played in their short season and the occasion seems opportune for a few notes upon the *Guyoscope*, and its times.

The *Guyoscope* was the outcome of a rather abnormal social condition at the hospital. The Disguysed Minstrels (Heaven save that ghastly punning name!) mixed up the men of various years in a much more complete manner than usual, and the common occupation of playing the fool before the public lent itself to the manufacture of local wit and local satire. The Gazette was then, as now, occasionally dull, and was always held to be of too official and sacrosanct a character to be debased by frivolity or humour of the personal and innocent nature for which an outlet was required.

It will be obvious, to go into history for a moment, that Mr. F. E. Fremantle being at that time editor of the Guy's Hospital Gazette, nothing below his hereditary and acquired standards of education and taste could be tolerated in its polished and rotund columns. So it was decided to start a paper, rival to the Gazette, in which, "burdened by no juxtaposition of professorial learning or clinical acumen, the foibles and peculiarities of the day might be adequately depicted." (Gibbon). Mr. B. B. Ham was the editor for the first, and Mr. J. M. Fortescue-Brickdale for the second year of its existence. Of their editorships more anon. Now that they are both beyond the reach of Decanal Nemesis, it will not hurt them to disclose their responsibtlity, though in the first early days of outraged dignity in St. Thomas's Street and the medical West End, it might have blighted their careers to a serious extent.

A caricaturist was essential, and Mr. Stanley Cock was at hand, so with characteristic self denial he gave up a promising dental career to the pursuit of Art, the Staff in their homes, and subscriptions to the *Guyoscope*. As his caricatures were the only work in the paper which were signed, he bore the brunt of many prophesies of woe, both for himself and his companions in crime. He was told by the Dean of those days (they are so different now), that he would end as a pavement artist, and he has done the next thing to it, for his work is now on all the hoardings. This gives one furiously to think, as the French say, which may be the worse, to be damned by the Dean and end your days miserably as a poster artist, or be made a dental house-surgeon, wear a frock coat and a top hat, and fulfil a godly life stopping the teeth of Brixton tradesmen. The other contributors were A. A. Miller, who wrote the pantomimes each Christmas, and the much quoted review of Hall Caine's "The Christian," W. R. Cazenove, who always wrote at the eleventh hour in many styles with much swearing, the late R. T. Fitz-Hugh who did "The Office Boy," the cockney contributions, A. J. Cleveland, T. L. Jackson and the two editors; Norman Oliver for poetry, and occasional contributors such as E. G. Goddard and W. S. Handley. Gerald Sichel sent drawings occasionally, and Murray Thomas drew fairly continuously throughout the second year. A few spasmodic writers occasionally volunteered, the majority reaching the W.P.B. For myself, I never wrote for it, but saw most of the paper's inner workings, and was one of the few who knew the meanings of most of the jests.

The peculiarity of the whole undertaking from the journalistic aspect was that the editors did no editing. They were certainly in a peculiar position; instead of suffering from a redundancy of copy as most editors do, they had to spend their lives soliciting unpaid contributions from lazy humourists. A blue pencil was unknown, and any contribution from the recognised staff was accepted bodily without criticism; there was no standard of morals or manners, and there was no regular day of publication. Nobody wrote anything until he was obliged, and the majority of each number was written at the eleventh hour under the urgent necessity of satisfying a clamant printer's devil needing "six pages more."

The editors wrote and didn't edit, and everybody took a hand at the proof sheets, or said they did, and consequently some articles got corrected twice over and some did not get corrected at all. Then when the paper came out all the staff blamed each other for carelessness.

The humour and taste of the paper were occasionally open to criticism, and it was often a legitimate source of offence in that it could not be left about with safety in the home. It was looked forward to none the less

eagerly however, and its Rabelaisian tendencies were pardoned for the sake of its redeeming wit.

That it did good in correcting little eccentricities on the part of those in authority, and that it cured men by ridicule of personal tricks and habits, and made the hospital a more mirthful and amusing place, there is not the slightest doubt. It was widely quoted both in the medical and lay press, and kept Guy's Hospital well talked about just when it needed advertisement during the great appeal for money in 1896–1898.

The men who ran it have reaped their reward in the kindly memory in which their names are kept at the hospital, and on the whole they probably made a more humane use of their time at the hospital and left it better men than many a prize winner or righteous resident. The attitude of the Staff towards them was divided; some were bitterly against the *Guyoscope* and vowed red ruin upon its perpetrators; others, probably the wiser, laughed at it, bore it no malice and left it alone. They all agreed, however, in thoroughly enjoying the joke when it was directed against a colleague rather than themselves. The wives of the Staff were among its constant readers, and none were so jealous as they of another's husband's notice.

In the other hospitals the *Guyoscope* had many ephemeral imitators, but none could compete with the original pioneer, and the present humorous writer in the columns of the GUY'S HOSPITAL GAZETTE savours strongly of imitative recollection at times.

Altogether the two years during which the *Guyoscope* was a power in the land were two of the greatest and best the hospital has had. It supported two journals, grave and gay; the Disguysed Minstrels, a troupe of about forty, were advertising the appeal and collecting money all round the suburbs, and with all this football and cricket were going strong and medals no rarer than they are now. The money the Disguysed Minstrels earned came to an end last year. Does not the present generation think that the time has come to make an effort to do as much for Guy's as their predecessors of 1895–1898?

LAUDATOR.

Nursing News.

MATRON'S OFFICE.

On January 17th, Nurse R. Johnson left the hospital on completion of her three years' training to take up her duties on the Private Nursing Staff. Nurse Stanyon has been appointed to succeed her as Head Nurse in Victoria Ward.

On January 21st, Nurse Tilly (Head Nurse in the Out-patients' Department) was transferred to Bright Ward.

In connection with the Nurses' Recreation Society, a League of past and present nurses has recently been established at Guy's Hospital. The Matron will therefore be glad to receive the name and address of every nurse trained at Guy's Hospital, in order that the aim and objects of the League may be brought under her notice.

In Lighter Vein.

IMPORTUNITY and our love of peace have carried the day—though it is breaking our usual rule never to publish unpaid advertisements, we feel compelled to grant MR. WACHER'S repeated request, and insert the following:—

PROGRAMME OF FAREWELL CONCERT.

Arranged by MR. WACHER for the benefit of MR. WACHER, on the eve of MR. WACHER'S departure on a starring tour round the Mediterranean.

Positively MR. WACHER'S last appearance in public this season.

Opening duet "The Better Land"
MR. & MR. WACHER.
Song "It's gone, there aint none" Dr. Bruce.
Recitation "The Better Land" MR. WACHER
with violin obligato by MR. WACHER.
Song "A little bit off the top" Signor Rahim.
Musical Sketch "The Better Land"
MR. WACHER.
Song "Our lodger's such a nice young man"
Dr. Fawcett.
Song "A Hunting we will go"
Mr. Clement Lucas.
Song "The Better Land" MR. WACHER.

God save the King (by kind permission of MR. WACHER).

All encores will be taken by MR. WACHER. Electrical effects by (and on) MR. WACHER. Photographs of MR. WACHER may be obtained for the asking from Copsey, at the Lodge.

Attendants are strictly forbidden to accept gratuities, all contributions should be given personally to MR. WACHER. Visitors to the concert are earnestly begged to assist MR. WACHER in carrying out this regulation, framed for his comfort and convenience.

Owing to Family ties, the Bird of Prey has been unable to send his usual contribution.

The Dental Society's Dinner.

THE Seventh Annual Dinner of the Dental Society was held on Saturday, February 8th, at the Hotel Cecil. The President, Mr. Ernest B. Dowsett, occupied the chair, and was ably supported by Dr. Shaw, Dr. Fawcett, Mr. Golding-Bird, Mr. Lane, Mr. Fripp, Mr. Maggs, Mr. Badcock, and other members of the Staff.

As in former years, there was a large gathering of past and present students. An excellent repast was provided by the Hotel authorities, to which, it is superfluous to add, full justice was done by those present. After dinner—

The CHAIRMAN rose, and in a short, well-worded speech, proposed the toast, "The King," and referred to the great interest which His Majesty had taken in Guy's Hospital. The toast was received with much enthusiasm and the singing of a verse of the National Anthem. After a brief interval, the Chairman again rose, and proposed "The Queen, the Prince and Princess of Wales, and the rest of the Royal Family." He alluded to His Royal Highness as a genuine chip of the old block, and made brief reference to the great enthusiasm which the voyage of the *Ophir* had evoked in the colonies.

This was followed by a duet by Messrs. Bowle and Wyatt, entitled "The Lovers," which was excellently rendered.

The toast, "The Navy, the Army, and the Auxiliary Forces," was then proposed by Mr. FRIPP, who referred to the splendid enthusiasm displayed by the colonies in regard to the war in South Africa, and thought that the ultimate good which would accrue from the war would greatly overbalance the loss of twenty thousand men and the expenditure of a paltry two hundred odd million pounds—serious items though they were.

Mr. GOLDING-BIRD, in reply, made a speech brimful of humour. It seemed most comic, he said, that he, essentially a man of peace, should be called upon to reply for the forces of war. Like a quick-change artist, Mr. Golding-Bird then replied for each of the three branches of the service, and each time at the expense of the other two.

Mr. ATKINS then appropriately sang "A Military Man."

"Guy's Hospital Medical and Dental Schools" was then proposed by Dr. SPRIGGS. He thought that the toast should be altered to "The School of Guy's Hospital," for the Medical and Dental Schools were one. His various witty sallies were well received.

Dr. SHAW, in replying, mentioned that it was the first occasion on which he had replied for the Medical School. The Dental School, when founded, was regarded by the older school, not with good maternal feelings, but rather with the indifference of a father towards his offspring. (Cries of oh! oh!) Now it stood in what he considered a most excellent relationship—that of a grown-up son to a middle-aged father.

Mr. RAY EDRIDGE then gave a recitation. He was vociferously encored, and gave Gilbert's "Bishop of Rum-ti-foo."

"The Dental Society" was then proposed by Dr. FAWCETT. After briefly outlining the history of the society, he mentioned that at present it was in a flourishing condition, the average attendance at the monthly meetings for this session being over fifty, as compared with thirty-five for last year.

Mr. WYNNE ROUW, in reply, stated that he was not used to making speeches; but gave a very different impression. In concluding, he told the following anecdote: "When I was coming in, I met a friend, who said, 'I see you are going to make a speech, Mr. Wynne Rouw.' I said 'I am.' He said, 'then for Heaven's sake, cut it short.' And I have."

Mr. K. BLACK followed with a bassoon solo, which was splendidly rendered, and enthusiastically encored.

Mr. R. P. ROWLANDS, in rising to propose "The Visitors," was received with tumultous applause. He scouted the idea that there was any rivalry between Guy's and other Dental Schools, as suggested by some of the previous speakers.

Mr. MORTON SMALE imagined that he had been asked to reply to the toast, as he held the dual office of Dean of the Royal Dental Hospital, and Examiner for the License in Dental Surgery.

Mr. Plummer then sang in good style, "Off to Philadelphia."

"The Chairman" was then proposed by Mr. J. H. BADCOCK, who did not wish to make the President blush by detailing in public his numerous virtues; but eulogized his professional ability and his skill as a teacher. The toast was received with musical honours.

Mr. ERNEST B. DOWSETT, in his reply, thanked the company for the honour which they had conferred upon him.

Mr. WYATT then sang "The Carnival."

Mr. J. LEWIN PAYNE rose and proposed "The Honorary Secretary and Treasurer."

Mr. J. E. SPILLER then replied.

Songs having been contributed by Mr. Atkins and Mr. L. A. Ransford, the proceedings terminated with the singing of "Auld Lang Syne" and "God Save the King"; and we went home with the firm conviction that the Seventh Annual Dinner of the Guy's Hospital Dental Society must be chronicled as a great success.

Appointments.

DR. LAURISTON SHAW is re-appointed Honorary Secretary to the Faculty of Medicine in the University of London.

NAVAL AND MILITARY.

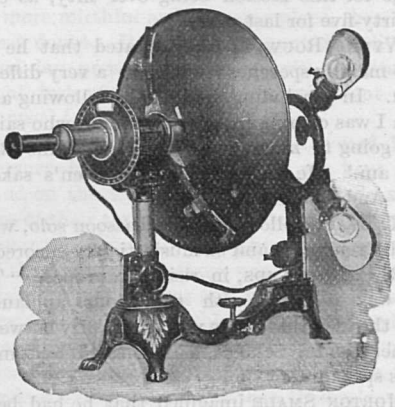
FLEET-SURGEON E. H. SAUNDERS has been appointed Principal Medical Officer, Royal Naval Barracks, Keyham, to date January 30th.

SURGEON HERBERT R. H. DENNY has been appointed to the *Thistle*.

SURGEON-CAPTAIN A. ALLPORT, 1st City of London Volunteer Artillery, resigns his commission.

Novelties.

AN IMPROVED OPHTHALMOMETER.



The Meyrowitz Manufacturing Company have considerably improved the ophthalmometer, designed by Javal, for estimating corneal astigmatism. In addition to various mechanical arrangements for moving the instrument so as to be able to adjust it readily and easily, they have improved upon the old "steps" and "parallelogram" reflectors, by Mires, consisting of a white field, with a black cross on it. This enables the operator to see more easily any slight difference between the curvatures of the two meridians, and by means of a graduated scale, to read off the number of diopters corresponding to the astigmatism. To those who have need of this instrument, and are wealthy enough to procure it, we can heartily recommend the Meyrowitz pattern, which can be obtained through the Anglo-American Optical Company, 47, Hatton Garden, E.C.

PINE FIBRE.

Samples of a fibre, made from the long-leaf pine growing in the Southern States of America, have been sent to us by the Davis's Feather Mills, Ltd., of 61–63, High Street, Whitechapel. It is intended for mattresses, pillows, etc. The odour is particularly pleasant, and the feel soft and springy. In addition, it is non-absorbent and durable. It should become most popular for upholstery purposes.

Papers by Guy's Men.

Notes on a case of Variola Hæmorrhagica. By W. Culver James, M.D., F.R.C.S. Edin.—*The Laneet*, 1st February.

On Rashes occurring after Enemata. By G. N. Meachen, M.B., M.R.C.P. Edin.—*Medical Times and Hospital Gazette*, 18th January.

Types.

No. 4.—THE MAN OF BLOOD.

"I was yesterday to dine at the Duchess of Piccadilly's . . . . I take a fine woman as some animals do their prey, stand still, and swoop they fall into my mouth."—GOLDSMITH.

(The Editor said it was too big a job for one so we both took it on). He was out.

The room was quaint if only in its novelty. Every wall bore some portion of his family tree with well-foliaged branches. There were nine emperors, fifteen kings, two hundred and forty-seven dukes, and quite a handful of bishops. All of which denotes blood. Round the walls, but well above the loftiest twigs, glowered face after face of noble ancestor in gilt frame. Some of them looked as if they had been hung before. A bookcase in one corner, loaded with many editions of Debrett, Burke, &c.; also a pocket Grey and one volume of "Aids to Surgery." As we sat down on a heap of old armour we noticed a couple of coronets and an ermine robe hanging behind the door. The room was absolutely cyanosed with blue blood. A soft footstep, a languid entry, and he appeared. We rose. He bowed slightly and shed a cuff. Then turning to me and referring to Kettle said, "Do I know him?"

I made the necessary introduction and said, "We should be glad——"

"So sorry my dear man that I'm late, but the King insisted on my staying to lunch, and," he continued dreamily, "there were such a lot of plates to wash up."

Kettle tried next. "Would you——"

"I know my dear fellow. You want to know about my people. My grandfather did some good work at Waterloo and was elevat——"

"What platform?" I enquired with renewed interest.

He glared at me icily and shed his other cuff.

"Then an uncle of mine—you may remember his town house; it stood on the site of the present Tate Gallery. He loved the dear old place, and they say for twenty years he never once passed through the gates. He was deeply engaged in geology. They say he got through more stones than anyone of his time."

"Is it true," I asked, "that the Duchess of Bermondsey threw herself down a drain for love of you?"

He smiled faintly. "Ah, these rumours; as a matter of fact, it was not the Duchess, dear woman, but the Lady Nora Neckinger. Poor girl, how she suffered."

"Sports," said Kettle, briefly.

"Yes," he responded. "I hunt a good bit. I caught a beauty yesterday. And I am a most enthusiastic fisherman. Why, at the moat in my place in Suffolk, I caught an eel once that was fifty feet long and nine feet round the chest. You needn't believe me, but I tell you that as a matter of fact. Were you at Lady Eclampsia's crush the other night?" he asked me suddenly, poking the fire with a bar sinister.

I gasped a negative.

"Dear Duchess, how sweet she was. She murmured to me as we met, two lumps, please. I left rather early before all the best people had arrived. There was some trouble about the spoons."

Kettle looked at me to put the next question. Suddenly a tap at the door. Our host spun round with a hurried, "Coming, sir, coming,' and disappeared quietly.

Through the closed door came the sound of a rough unmusical common voice. "Yus," it said, "The guvnor 'e says as ow you cawnt 'eve thet dress soot ternoight cos anuvver gent as oired it."

This seemed to be a private matter so we left.

POTT AND KETTLE.

From the Gazette's Special Pathologist.

A., Chadwell Heath.—No tubercle bacilli were found in the specimen of sputum.

H., Reigate.—Tubercle bacilli were not found in the specimen.

H.G.A., Nottingham.—This is a typical scirrhus carcinoma of the breast, which has already infiltrated the surrounding fatty tissue.

F., Chorley Wood.—The tubercle bacillus was not found in this specimen of sputum.

PATHOLOGIST.

Chapel News.

The Services in Chapel for the first two weeks of Lent are as follows:—Sundays: Holy Communion, 7 and 8.45 a.m. (and at 6 a.m. on March 2nd). Matins and Sermon, 11 a.m. Evensong and Service, 7 p.m. Preachers: Feb. 16th, at 11 a.m., Rev. P. H. Bown: at 7 p.m., Rev. H. F. Le Fanu. Feb. 23rd, at 11 a.m., Rev. W. G. Boyd, Curate-in-charge, S. Faith, Stepney; at 7 p.m., Rev. H. F. Le Fanu. Wednesday, Feb. 19th, at 8.15 p.m., the Rev. the Hon. A. G. Lawley, Rector of Hackney. Wednesday, Feb. 26th, at 8.15 p.m., Rev. E. M. Blackie, Rector of Limpsfield.

Pass List.

The Conjoint Board in England.

EXAMINATION FOR THE DIPLOMA IN PUBLIC HEALTH.

Francis Edward Fremantle, M.B., B.Ch., M.R.C.P., M.R.C.S.

University of London, January, 1902.

INTERMEDIATE EXAMINATION IN MEDICINE.

Entire Examination—Second Division.—R. Felton, F. P. Hughes, D. Isaacs, A. Leeming, W. N. May, J. McF. W. Pollard, A. M. Roome.

PRELIMINARY SCIENTIFIC EXAMINATION.

Chemistry and Experimental Physics.—*G. F. E. Allison, *C. A. Basker, *J. A. Bullbrook, *H. E. H. Mitchell.

Biology.—*S. W. Daw, A. F. W. Denning, *A. L. Foster, *C. H. Marshall, *A. Zorab.

* Denotes completion of examination.

Sport.

Owing to very great pressure on our space a considerable portion of sporting news has had to be held over.

Rugby Football.

INTERNATIONAL RUGBY CUP-TIES.—FIRST ROUND.

GUY'S v. ST. BARTHOLOMEW'S.

Much interest centred in this fixture, which was decided on the Richmond Club Ground on Tuesday, the 4th instant, as it was generally conceded that Bart's and Guy's were the two strongest teams entered, and that the winner of this match should, barring accidents, capture the cup. We were not at our best as Anderson was an invalid, and Harrison and Cutler were barely

convalescent. The weather was bitterly cold, and the ground somewhat treacherous, by reason of its greasy surface, but fortunately there was no wind to speak of. Little time was lost in preliminaries, and at seven minutes past three Bart's kicked off, Harrison did not take the ball well, and his kick into touch at once brought our opponents up to within ten yards of our goal line; however, a good rush by Guy's forwards took the game to the twenty-five yards line. Here a series of scrums proved Bart.'s slightly the better pack, but their success in getting the ball was nullified by the wild passing of their backs, and Payne's smartness at half. He, however, just overdid this, and a free kick was allowed, which took the ball into touch in our twenty-five. By some smart open work our forwards relieved. Our opponents' three-quarter line got away, but good tackling on the part of Glendinning and McEvedy prevented their doing much. Guy's pressed now, and the forwards heeling out well gave an opening to McEvedy, who transferred to Alcock; the last named was not to be denied, and forced his way over the line far out on the left. O'Brien took the kick, which was a very fair attempt, from a difficult position, just missing the right post by a few feet.

Alcock received the drop out, and returned into touch at the twenty-five flag. A ball picked out from a scrambling scrum was worth a free kick to Bart's but availed little, as McEvedy, O'Brien and Morgan came away well, the last named unfortunately knocking on. Another bit of combined passing nearly ended in the left wing getting over, but Alcock just failed to take the ball and a good rush, headed by O'Neill and Tosswill, relieved St. Bartholomew's. Payne took the ball well from the scrum, riggled through the pack and passed to Thomas, the last fell, but transferred to Alcock, who was well tackled. Further close scrumming ended in a smart run by Morgan to Bart's twenty-five, and this was followed by a good bit of dribbling by Payne, but the ball went into touch in goal. Harrison was not up to form in his kicking, and Bart's soon pressed again, their efforts being neutralised by a pretty forward rush, in which Thomas and Ward were prominent. Our forwards for some time had the worst of the scrums, and Bart's pressed but always lacked the necessary finish. Cutler saved well, and relieved with a short kick, and from a mark O'Brien tried a shot at goal. It was a good kick, but to the right of the posts Thompson, who had a good strategetic position, was put on side by fumbling on the part of one of our opponent's backs, but just failed to score a try as the ball was kicked from under him, and his effort resulted in a nasty rick, which handicapped him during the rest of the game. Equally unfortunate was Thomas, who soon after twisted his knee. These defections in our pack, and the grand efforts of Bart's. scrimmagers, well led and controlled by Tosswill and O'Neill, caused our backs to remain on the defensive; but they were very sound, and the opposing outsides were never really dangerous, although it looked at times as if their forwards might force our line. A free kick at goal gave them another opportunity, of which they did not avail themselves, and half-time found it anybody's game, and Guy's only three points in hand.

Tolhurst kicked off but Payne's costume became somewhat too airy for the weather, and a halt was called to allow him to refit. Bart.'s had two more shots at goal from free kicks, but a useful sprint by Alcock along the line brought the game back into the enemy's quarters. Their forwards screwed the scrum and got away well but Morgan found touch. A good opening which Morgan made for Alcock by cutting across to left, was lost by the latter fumbling; and Bart.'s found touch in their own twenty-five. Alcock tried to dash through the line out but O'Neil intercepted, and play was transferred to our twenty-five. Tosswell also got away from the line out and looked dangerous, but our forwards came away with a fine loose rush, and Harrison relieved with a useful kick which he followed up. Payne now got the ball away to Alcock who took it neatly on the bounce, ran down the touch line, and handed off the full back, grounding between the posts; Morgan converted with a neat kick, and with 8 points to the good we breathed more freely.

Our three-quarter line got in some good passing, but Morgan was always well marked. Still another free kick was allowed to Bart.'s as Tosswell was obstructed by Harrison, a "no charge" was also granted but nothing came of the attempt at goal. Bart.'s only once more looked dangerous, but O'Brien found touch with a good kick, and Morgan taking a pass well from Cutler ran up the line but was pushed into touch. The close of play found the game in neutral territory and Guy's the winners by 8 points to nil. Team:—

ST. BARTHOLOMEW'S.—E. S. Marshall (full back); D. M. Stone, J. Corbin, H. B. Owen, G. G. Ellett (three-quarter backs); D. M. O'Neill, W. H. Scott (half-backs); T. A. O'Neill, T. R. Tosswill, H. T. Wilson, A. R. Nelyan, H. E. Stranger-Leathes, W. H. Hamilton, G. H. Adam L. Morris (forwards).

GUY'S.—E. M. Harrison (full back); E. Morgan, A. O'Brien, P. F. McEvedy, F. Alcock (three-quarter-backs); O. V. Payne, M. C. Wetherell (half-backs); H. A. Cutler, T. P. Thomas, R. C. Lawry, A. R. Thompson, A. M. Tolhurst, B. Glendinning, E. H. B. Milsom, E. L. Ward (forwards). Referee: Mr. E. V. Gardner.

Birth.

SMITH.—On February 7th, 1902, at 24, St. Thomas's Street, the wife of Guy Bellingham Smith, M.B., B.S., F.R.C.S., of a son.

Marriage.

COPLEY—FOWLER.—On January 8th, 1902, at St. James's Church, Stamford Hill, Durban, South Africa, by the Rev. Thomas Goodwin, Stanley Copley, F.R.C.S, of Stamford Hill, to Kate Gwendoline Fowler, daughter of Edwin Fowler, J.P., of Hill Grove, Pontypool, England.

Deaths.

JOHNSON.—On January 18th, at Dallas Road, Lancaster, Surgeon-Major Metcalfe Johnson, in the 79 year of his age.

POOLE.—On January 9th, at the British Legation, Pekin, Wordsworth Poole, C.M.G., B.A., M.B., B.C., aged 34 years.

ED.—D. G. G.

Contents.

	PAGE
GONORRHŒAL ARTHRITIS: Clinical Lecture by Mr. Jacobson	85-91
DEATH OF MR. HENRY HEYWOOD	91
CORRESPONDENCE: The Museum	91
IN LIGHTER VEIN	92
THE SMOKING CONCERT	92
CHAPEL NEWS	93
NURSING NEWS	93
NOTICES	93
PRIZE EXAMINATIONS, 1902	93-94
GUY'S HOSPITAL OFFICERS' AND SERVANTS' DINNER ...	94
PASSIM	95-97
MEDICAL HERESIES	97-101
TYPES	101
REVIEW	102
SPORT: Rugby Football—Guy's v. Kensington; Guy's v. Croydon; Guy's v. London. Association Football—Guy's v. Ewell; Guy's v. Reigate: Guy's v. Bart.'s ...	102-104

Calendar of Coming Events.

March, 1902.

Sat. 1.—Messrs. Jacobson and Fripp's take-in; Drs. A. R. Brailey and D. R. Pike; Cl., P. N. B. Odgers.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Marlboro' Nomads, home.
II., " II., away.
G.H.A.F.C., I., Idlers, home.
II., Leavesden Asylum, away.
April Appointment List opened.

Mon. 3.—1.15 p.m., Clinical lecture by Mr. Higgens.

Wed. 5.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.A.F.C., I., Richmond, away.

Thur. 6.—Messrs. Howse and Symonds' take-in; Drs., J. S. Cooper and J. Braithwaite; Cl., W. M. Robson.
G.H.C.U., Address by Rev. W. T. Hollins, M.A.

Sat. 8.—April Appointment List closed.
1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Harlequins, away.
II., Merchant Taylors' School, away.
III., Polytechnic "A," away.
G.H.A.F.C., I., Ramsgate, away.
II., Surbiton Hill 2nd XI., away.

Mon. 10.—1.15 p.m., Clinical lecture by Mr. Laidlaw Purves.
Exam. for Arthur Durham Dissection Prizes.
Application to Med. Sch. Office for Schedules for the First and Second Conjoint Exams. to be made not later than this date.

Wed. 12.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.

Thur. 13.—Messrs. Lucas and Lane's take-in; Drs., H. S. Brown and A. R. Wilson; Cl., A. R. Thompson.
G.H.C.U., Address by Rev. Thos. Currie, M.A.

Fri. 14.—Meeting of the Dental Society at 4 p.m.

Sat. 15.—1 p.m., Clinical lecture by Dr. Taylor.
G.H.R.F.C. I., London Irish, away.
II., Croydon II., away.
G.H.A.F.C., I., Tunbridge Wells, away.
II., Ewell 2nd XI., away.

Guy's Hospital Gazette.

MARCH 1, 1902.

Gonorrhœal Arthritis.

CLINICAL LECTURE BY MR. JACOBSON.

GENTLEMEN,—In choosing the above subject, I desire to draw your attention to the following points especially:—

(1) The difficulty which may sometimes be met with in diagnosing the disease before us, and

(2) The occasional grave importance of gonorrhœa, especially in women.

I will begin by reading a letter I hold in my hand—

November 1st, 1900.

"When you have some female beds at your disposal, would you give an admission order for a case of tubercular (?) periostitis of barely two months history? It began on right hand, and spread up the arm, local abscesses formed over the third metacarpal, base of thumb, and midway up the cleft of the ulna. All these were opened, and well scraped a week ago. Temperature is still up, 101° each night, and now the left wrist-joint is affected. I question much whether something more drastic should not be done now to prevent the mischief spreading."

Now for the patient, the condition we found on admission, the reason for a different diagnosis, the treatment and its results. The woman admitted into Guy's Hospital, November 7th, 1900, was aged 31, married, her husband being a country butcher of the usual build and type, physically and otherwise. There were two healthy children. The patient had had an attack of "rheumatism" eight years ago. Her information was vague on this point; the mischief at that date affected the shoulders, wrists, and some of the finger-joints. All the information which it gave to my mind was, that it perhaps pointed to the patient being of what Mr. Hutchinson, following Bazin, calls the arthritic diathesis, and therefore liable to acute rheumatism, gout, or osteo-arthritis; further, the fact that one wrist-joint had been affected, showed that this joint had been perhaps left weakened in the event of its having to meet invasions of micro-organisms. Seven weeks before her admission, after a day's washing, the right wrist

was noticed to be swollen and painful, tenderness and redness being especially marked on the dorsum. Note here the mode of onset of the arthritis. You are all familiar with the part that a slight injury plays as an exciting cause of a tubercular lesion as when a joint is sprained in a patient of poor resisting power, and the bacilli of tubercle at once obtain a good footing in the cell exudation which has followed on the sprain. But the micro-organisms of tubercle are, though amongst the commonest, not the only ones which we have to remember as dwelling in our patients' systems, and actual cell exudation is not needed to enable such organisms to obtain hold. Fatigue alone of a part without any cell exudation, will in some cases, weaken the tissue enough to reduce the immunity of the patient sufficiently to allow infection to take place. This has been shown, for instance, by making a rat, which is ordinarily immune against a third set of micro-organisms, namely, those of anthrax, tire itself out by working in a wheel-cage, after which it can be affected. The fact that the swelling appeared chiefly on the dorsum is explained by the presence here of the extensor tendons and their sheaths.

We shall see a little later that a common variety of gonorrhœal arthritis attacks not only the capsule of the joint, but the pericapsular structures, and especially tendon sheaths. Three incisions were made by the medical man in charge. Six weeks later a similar swelling appeared in the dorsum of the *left* hand. The patient was now sent up with the diagnosis of double tubercular arthritis. Condition on admission: On the *right* side there were three sinuses, one over the fourth metacarpal bone, the other two higher up near the radial styloid process. The highest, four inches long, clearly followed a tendon sheath. No evidence of tubercular mischief or caries. All the joints on this side, both of hand and wrist, were extremely stiff. The dorsal aspect of the *left* wrist showed marked swelling and œdema, together with distinct tenderness. The last mentioned made it difficult to say whether any fluctuation and synovitis was present, while the application of iodine made it impossible to detect any redness or inflammatory blush. On this, the left side, that most recently attacked, there was much less stiffness, and this fact made it easy to detect some crackling as often occurs along the extensor tendons. My diagnosis was, that we had to do with gonorrhœal and not tubercular mischief, and to make certain, I requested the sister of the ward to find out if any vaginal discharge existed. My reasons for coming to the above conclusion were as follows:—(1) The condition of the sinuses resulting from the three incisions made on the right side before the patient entered the hospital. Though six weeks had elapsed since the incisions were made, there was an entire absence of anything suggesting tubercular infective granulation tissue, that tissue which you will find in tubercular lesions, whether of bones, joints, or glands; the granulation tissue present was weakly, and that was all. (2) There was no evidence of that pain and disorganisation, none of that aspect of illness and suffering which would have been expected in a woman the subject of tubercular arthritis of both wrists, with on one side, mixed infection present. (3) On the other hand, the evidence we had on the left side, the œdema, tenderness and teno-synovitis, all occurring spontaneously and secondarily to an attack on the other side, all these were characteristic of one variety of gonorrhœal arthritis as I shall show you later. (4) Lastly, there was the rapid progress of the case, this had only lasted two months, and had already brought about an amount of mischief quite unlike the insidious, slow progress of tubercular mischief in its earlier stages. The diagnosis was confirmed by the sister reporting next day that a vaginal discharge was present, and that it had a yellow tinge. I will take this opportunity of making a few practical remarks upon the gonorrhœal discharge in these cases which may be useful to you in practice. The gonorrhœal discharge in these cases may be profuse, it may be gleety, sometimes its existence is denied; careful and repeated examinations will be needed here, and the intentional fallacies of micturition or injections used just before your opportunity of examination, will have to be remembered. If you have several strong grounds for being sure of your diagnosis, do not be too much worried because one, however important, is wanting, the diagnosis of disease

is not infrequently missed because the medical man thinks too much of a typical case of the disease; as you grow older you will find how often the manifestations of this or that disease tend to be "atypical." I shall have a little more to say with regard to the apparent absence of a discharge, and the impossibility of finding gonococci in men, in whom the facilities for investigation are so much greater, though all the time they are the subjects of gonorrhœa. To keep for the present to the presence or absence of vaginal discharge in cases of gonorrhœal arthritis, I find it better in hospital practice in these and allied cases to ask the sister of the ward to make any needful enquiry. The privacy with which it can be done is more considerate and delicate, and I have generally found it effective. And here is a minor advantage of hospital, over private practice. Just suppose a woman with gonorrhœal arthritis denies the existence of a discharge, and in a day or two later one is found to be present, she is not necessarily a liar, far from it. For reasons already given, the discharge may be present one day and not the next, and remember some differences in the two sexes. A man cannot help seeing that he has a discharge. From the differences in the urethra, and in micturition, a woman, especially an innocent one, and when the discharge is mild in infection or chronic, and painless, may very easily remain in ignorance. Again, in a man such a discharge comes only from the urethra, which is under his observation every time that he makes water. In a woman the discharge may be from an infected uterus. Again, not only modesty and ignorance, but indifference has to be reckoned with, especially in poorer patients. The life of these women is so hard and fully occupied, they are so used to discharges of one kind or another, such as that of menstruation, leucorrhœa, and so forth, that a discharge accompanying gonorrhœal arthritis may be ignored. Remember, lastly, that where the patient is a woman and an innocent one, there is no convicting conscience, while often there is someone guilty behind. And this recalls another point. I remember that it amused those with me when I drew attention to it. The husband was exceeding assiduous in his visits, and attentive and always anxious to overhear what I had to say to those around me about his wife's case. I thought he rather overdid it. You will, when in practice, see cases in which your diagnosis of venereal disease in respectable married women will at times be strengthened, and your suspicions confirmed by some anxiety on the part of the husband, often the guilty party in the background, on this subject I shall quote from a third letter—when the wife is probably innocent. On the other hand, let me mention the opposite characteristic as a possible guide—*sereneness, over-sereneness*, or feigned ignorance of the meaning of my enquiries clearly understood—has in one case where the wife was far from innocent, led to a confirmation of my suspicions, a recognition of the fact that the source of the disease was more than guessed at, and a confession as to the correctness of my suspicions.

To return to the case and its further course, the sinuses on the right side were curetted, and pure carbolic acid applied. The left wrist was put up in plaster of Paris, and active and passive movements of the fingers carried out regularly, the granulating surfaces on the right side quickly became healthy, and similar support and fixity were given on this side also. The patient returned home November 14th; all effusion, redness and tenderness had disappeared, two of the sinuses on the right side had healed, and the third very nearly. The movement of the fingers was good on both sides; the thumbs were somewhat stiff. The patient was warned as to the need of keeping up active and passive movements, but now that the danger of "consumptive" mischief was off her mind she did not seem to attach sufficient importance to our advice. The medical man, in answer to a letter of mine replied—

February 27th, 1901.

> "Yes, you were quite right, there has never been the slightest trouble since. Mrs. A. has acquired the movement in the left hand and wrist perfectly; in the right, the fingers can be flexed into the palm. The thumb and wrist are still stiff."

Finally supplying the last link in the history of the case, and clinching the diagnosis, the medical man was good enough to write to me spontaneously in April, 1901, saying—

> "You will be interested to know that I am now attending the husband of the last case for a gleet."

I turn next to the pathology of the disease before us to-day, by the name I called it in the heading of my lecture, Gonorrhœal Arthritis. This is a term which everyone desiring to be scientifically accurate should use, and this alone. By it we mean an inflammation of joints due to the presence of the gonococcus or its toxines. We shall see a little later what forms the gonorrhœal arthritis may take. Such terms as gonorrhœal synovitis, gonorrhœal rheumatism, urethral arthritis, should be given up absolutely. Gonorrhœal synovitis only denotes one form of gonorrhœal arthritis, and is thus incomplete; the term urethral arthritis is inaccurate, as it implies that this form of joint disease is always due to trouble in the urethra, whereas, Mr. Clement Lucas, Deutschmann and others have shown that gonorrhœal arthritis may be due, in infants, to gonorrhœal conjunctivitis. I will discuss a little later the objections to the term gonorrhœal rheumatism.

Causation.—As with the name so with the cause, different views have been held out; they should now all be given up, save one. (1) The arthritis is due to (*a*) gonococci themselves, or (*b*) their toxines. The evidence has of late years been increasing in amount and clearness that this arthritis is a specific one. The cases are now mounting up in which gonococci have been found in the fluid removed from these joints, and it is certain that failures to find them in the other cases when they have been looked for—an investigation only made in recent years—have been due sometimes to mistakes or deficiencies in the technique employed, but chiefly to difficulties in the detection of the gonococci. These difficulties are many. To begin with, gonorrhœal arthritis often occurs in the gleety stage, the existence of which may be denied by the patient, which may require repeated opportunities of inspection for its detection. In this gleety stage the gonococci are few in number, and lie deeply in the deeper epithelium of the urethra, even in the subepithelial tissues, or in the numerous lacunæ, follicles and gland ducts of the anterior and posterior urethra. If the above difficulties exist, in detecting a gleet in a man, they are obviously increased in a woman, not only for the reasons given above, but because the gonococci are not now on the surface, but deeper as in the ducts of Bartholin's glands, and within the uterus. Here, as in man, the gonococci may still be present in the tissues, though not discoverable in any discharge that has been detected. With other difficulties you must be familiar, though I have no time to dwell on them here. Amongst them are the difficulties that micro-organisms are found in the human urethra, which in size, shape and grouping closely resemble the gonococcus; the rather complicated technique of Rouxs' method of staining, by which the gonococci, like other cocci, are first stained with a solution of genetian violet, and then on the application of Gram's liquid (iodine 1 part, potassium iodide 2 parts, and 300 parts of water) followed by absolute alcohol, all the gonococci will have dissappeared, while any other micro-organisms present all continue visible. Finally, these are the difficulties of cultivation, the dislike of the gonococci to the ordinary culture media, their frequently short tenure of life when they make a start, and the ease with which they allow themselves to be crowded out by the pyococci, if present—difficulties which can only be met by the skilled hands and special experience of a bacteriologist. What the bacteriologists can do to meet the difficulties met with in cultivating the gonococcus is shown by an interesting number of papers. I recommend one especially to your notice, "A report of Successful Cultivations of the Gonococci from cases of Arthritis, Subcutaneous Abscess, Acute and Chronic Cystitis, Pyonephrosis and Peritonitis," published in the Journal of Cutaneous and Genito-Urinary Diseases, June, 1900, by Dr. H. J. Young, of the Johns Hopkins University.

At first thought the enumeration of these difficulties in the detection of the gonococci may dishearten you. But there is not the least necessity for this. In any case of obscure arthritis where you suspect gonococci but cannot find them, you must act as you do in cases of suspected growth of the bladder, where you have had no practice with the cystoscope, or in one of supposed renal calculus where skiagraphy is negative.

Though these special aids may be absent, your experience if accumulated by steady work here, your judgment if cultivated by the opportunities which this place gives, will very largely replace them. Given a doubtful case of arthritis which may be gonorrhœal, the experience which you are sent here to gain, will enable you to exclude other forms, while it will recall to you some at least of the features which, as I shall show you later on, characterise this variety of arthritis. If the patient be one who may have had gonorrhœa, you will use your common sense and treat the arthritis accordingly, whether the history of any discharge is denied or acknowledged; the results of your treatment and the test of time will usually prove you right.

(*b*) In some cases we must remember where gonococci cannot be found the arthritis may be due, not to the gonococci themselves, but to their toxines. In the mode of causation of the gonorrhœal arthritis which we are considering, the joint trouble is usually produced by the gonococci gaining entrance into the articulations by the blood-stream, but you are aware that it is part of the physiology of bacteria to manufacture poisonous substances—and some of these are amongst the most powerful poisons known—which are named toxins, some of these poisonous substances act as ferments, and produce poisons by acting upon the tissues which they reach, especially the albuminous ones. Here is another way in which gonorrhœal arthritis may be produced, viz. by the toxins of the gonococci. Given a patient of poor vitality, as many of these patients with gonorrhœal arthritis are, it is not difficult to see that the toxic chemical products of the gonococci shall in certain cases have a poisonous effect upon the tissues of these patients' joints. One of the most terrible instances of this power of the gonococci to produce deadly toxins, is related by Sir W. Gowers in the *Clinical Journal* for December 20th, 1893. The patient was a young man aet. 19, overworked, and in poor health, who had had gonorrhœa a month before, this disease being thought to be cured in two weeks. One week later, five weeks after the onset of the gonorrhœa, weakness of the lower limbs and abdominal muscles set in. During the next few days this paralysis crept upwards to the head and upper extremities, and the lad died a few hours later with urgent dyspnœa. Here the toxins of the gonococci, instead of seizing on the joints and bringing about a gonorrhœal arthritis, had acted upon the tissues of the spinal cord, bringing about a rapidly fatal myelitis. (*c*) A third view must be mentioned, that of Tillmanns, the Professor of Surgery at Leipzig, that gonorrhœal arthritis is due to a mixed infection, that of pyococci as well as gonococci. That this occurs occasionally is more than probable; that a mixed infection is not the cause, as a rule, is shown by the character of the arthritis. This is rarely acute, more commonly sub-acute, and much more frequently chronic. Then the result is not like that met with in arthritis in which pyococci have played a part. Any fluid drawn off may contain gonococci but very rarely pyococci. Lastly, crippling adhesions are the rule not destruction of the joint surfaces. Having seen that gonorrhœal arthritis is due directly or indirectly to the gonococci and to these only, we will first consider the other theories that have been put forward for its causation. These are two. The rheumatic or gouty theory. According to this view, gonorrhœal arthritis occurs only in patients of a rheumatic or gouty diathesis, the gonorrhœa awakening a latent and predisposing taint. The objections to this view are many and insuperable; (*a*) Rheumatic and gouty remedies are useless, and in most cases harmful. We shall see that one reason why the treatment of this troublesome form of arthritis has been so unsatisfactory is, that these remedies are given so frequently and so futilely. (*b*.) Gonorrhœal arthritis may occur in patients without any such taint, *e.g.*, new-born infants with gonorrhœal ophthalmia (Clement Lucas, Deutschmann, and others). These are the chief objections to this view; others are, (*c*) Patients with gonorrhœal arthritis are not found to be gouty or rheumatic. Thus, Dr. Pye-Smith (Guy's Hospital Reports, 1864, p. 344) out of twenty-nine patients, only found three who stated that they had suffered previously from rheumatic fever, which had, however, left no trace upon the heart. In five cases only were

there family histories of rheumatic fever, gout, or rheumatic past, and in some of these five the evidence was far from satisfactory. More recently, Dr. J. Stewart (*Montreal Med. Journ.*, 1900, p. 174) in observations on forty-eight cases of gonorrhœal arthritis, found it impossible to make out that there was any relation between a previous rheumatic history and a subsequent attack of gonorrhœal arthritis. (*d*) Gonorrhœal arthritis has very little in common with the arthritis of rheumatism or gout (*vide infra*).

The pyæmic theory. This view was based on a fallacy, and like all views with such foundations must fall. It being believed in former days that pyæmia was due to the absorption of pus, it was held that gonorrhœal arthritis was brought about by the absorption of pus from the urethra. And the greater frequency of the disease in men, a frequency which has been much exaggerated, was held to be due to the greater length and the more complicated structure of the male urethra. From the pathology of the disease, I pass on to the varieties of gonorrhœal arthritis and their diagnosis. Of the varieties there are two, and two only, which are common. Remembering these you will be safe. (1) Gonorrhœal synovitis or gonorrhœal hydrathrosis or gonorrhœal hydrops. Effusion of sero-synovial fluid is here the distinguishing feature. The amount of fluid varies. The joints most frequently attacked by this variety are, in my experience, the knee and the ankle. The constitutional disturbance is seldom great, the obstinacy of the local pain and swelling being the most important symptom. To these and other points I shall recur a little later. (2) Gonorrhœal phlegmonous arthritis (Duplay and Bruns, Davies-Colley). In this variety the arthritis is accompanied not by much effusion of fluid, such effusion being slightly marked, if present at all—but by œdema infiltration of the pericapsular tissues in relation with the capsule. From the fact that this œdema involves the skin and subcutaneous tissues, that it is often accompanied with redness and pain, that the redness and œdema often extend beyond the limits of the joint, the term phlegmonous has been given to this variety of gonorrhœal arthritis. Further, the above characters, together with their acuteness of onset, and the feeling, or fancied feeling of fluctuation in the pericapsular œdema incisions have often been prematurely made. Pus is never present unless it be a case of a mixed infection, which we shall see shortly to be very rare. The late Mr. Davies-Colley, who drew attention to this form of gonorrhœal arthritis (Guy's Hospital Reports, 1882, p. 187), thus clearly puts the chief points, "This acute form is quite as often found in the female as in the male, perhaps more often. It usually begins before the gonorrhœa or discharge has existed for any considerable time, and the subjects are generally under the middle age. The onset is like that of an attack of acute rheumatism. The patient is feverish, and has pain, tenderness, and swelling of several joints, the symptoms are often so severe that he has to take to his bed. In a few days the inflammation leaves all the joints save one, in which it concentrates itself with great severity. This may be any one of the larger joints. I have notes of its occurrence in the knee, ankle, wrist and elbow joints, as well as in those of the carpus and tarsus. Most frequently I have seen it in the elbow. The appearance of the joint is not at all like that which is seen in acute synovitis. There may be effusion within the synovial sac, but the most striking characteristic is the œdema of the soft parts around the joint, accompanied, as a rule, during the height of the attack, by redness of the skin. The swelling is in some cases very great, and when the elbow has been affected, I have seen the redness and œdema extending from the shoulder to the wrist-joint. I believe that the superficial effusion is due to the inflammation having attacked especially the fibrous tissues of the capsule, rather than the synovial membrane by which it is lined. The slight amount of effusion which occurs in the synovial sac is probably secondary to the affection of the adjacent fibrous tissues. The joint is very tender, hot, and full of pain, and any attempt to move it gives rise to excruciating pangs." These two—(1) the gonorrhœal synovitis, and (2) the acuter phlegmonous arthritis and periarthritis, are the only two common forms in which gonorrhœa attacks the joints. The following

may, though very rarely, occur. (3) A mixed infection. A gonorrhœal arthritis together with suppuration. This, if common, would be extremely serious from its liability to cause a destructive arthritis, and to be accompanied by pyæmia. It is easy to explain in a measure why the mixed infection is rare. Acute gonorrhœa is due to the gonococci, and one or more of the pyococci, in other words, it is a mixed infection. But note now these two points. Gonorrhœal Arthritis is not met with usually in the acute stages of gonorrhœa, the stage in which a mixed infection is present, viz., pyococci as well as gonococci, but in the later subacute or gleety stage. At this stage to the unguarded eye, the discharge may have ceased to be purulent, it may be only the mucous discharge of a gleet, but it may be highly infectious still owing to the power the gonococci have of lying dormant inside cells and in the deeper recesses, glandular and otherwise, of the genital and generative passages. Pyococci have not this power of survival and persistence, partly because they have not the same power of penetrating the cells, and thus are found free by the urine which frequently flushes out the urethra, the first part attacked by the disease as a rule. While, however, the pyococci do not long survive, and so, as a rule, do not take part in the arthritis, a later complication of gonorrhœa, they take part, sometimes, they alone have a part in the earlier complications of gonorrhœa, *e.g.*, bubo. Of the two other varieties of Gonorrhœal Arthritis I know nothing, I mention them to you as they are described by a reliable writer of great experience, the late Mr. Berkeley Hill (Syphilis and Local Contagious Disorders, page 562). (4). To this form of gonorrhœal joint trouble, Mr. B. Hill gives the name of the arthralgic variety, because the chief symptom is pain. "This pain attacks one joint or several successively, but is most severe in one of the larger joints. The movements of the joints are not affected, nor are there any objective signs of morbid action in the articulation which is the seat of pain. This variety is much more often attendant on chronic urethritis and old gleets. (5). To the last variety, Mr. Berkeley Hill gives the name of knotty or pseudo-gouty, as here the small joints of the fingers and toes become thickened and deformed. As I have already said, it is the two first—the variety of hydrarthrosis and phlegmonous arthritis and periarthritis with which you should be familiar.

(*To be continued.*)

Death of Mr. Henry Haywood.

By the death of Mr. Haywood, the Governors lose the highly valued services of their Resident Agent on the Herefordshire property of the hospital.

Mr. Haywood was, probably, the most experienced land agent in the county, and his ripe experience and fine judgment were much sought after by landlords and tenants alike. To his position of Vice-Chairman of the Herefordshire County Council, and as a Magistrate for the County, Mr. Haywood brought a thoroughly practical and trained intelligence which an agricultural county can, at the present time, ill afford to lose. In earlier years he was a keen sportsman and courser—his dog Rebe running second, two years following, in the Waterloo Cup, while his breed of Hereford cattle was far famed.

Mr. Haywood died in his 83rd year, at his own estate at Blakemere, near Hereford, on the 19th instant. Mr. Henry Williams, the Clerk of the Hospital, represented the Governors at his funeral last Tuesday.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Museum.

Sir,—May I draw attention in your columns to the extremely unsatisfactory state of the surgical pathological section of our museum? Not only are many of th specimens numbered wrongly, but the catalogue is in such a state of chaos that very few of the specimens can be identified without a vast amount of trouble. Even if that be accomplished the remarks upon them that have been written are often unintelligible unless one is blessed with the gift of second sight. Again, many of the preparations appear under titles that have long since been discarded and are almost unknown to present day men. Pathology and morbid anatomy are difficult subjects and are stumbling blocks to many men. The medical side of the museum has undergone wondrous alterations and a similar improvement is promised for the surgical side, but it has been a long time coming. It is very badly needed, especially as one has little or no opportunity of learning anything of surgical pathology at autopsies.

—I remain, sir, yours, SURGICAL.

In Lighter Vein.

(This article will not be published in the Reports.)

A RESEARCH UPON THE ÆTIOLOGY OF TINEA RESIDENTORUM. By M. R. STENCH, L.O.A., R.S.V.P., M.D. (brass plate) and JAMES FOOTLER, F.O.S., P.P.H., B.I.D., etc.

Preliminary. For the convenience of subsequent writers on this most irritating subject, we have arranged our material under various sections.

* by one of us.

Section I.—*Who we are.*

M. R. S., Member of the Ancient Order of Oddfellows; Champion Ping Pong Player; Owner of the largest Hat on record.

J. F., late Porter S.E.R., Fellow of the London Bridge Toilet Club; President Society of Sparrow Starvers.

Section II.—*Why we did it.* We had it.

[Here follow explanations, &c., which are best left unwritten.—ED.]

Section III.—(439 tables, a map of the world and a plate representing "Common Objects of the Seashore.") [Also omitted.]

Section IV.—*Methods employed.* The subject was carefully weighed* and washed,* and the washing collected in the hat. This necessitated much night work as the hat was in use during the major part of the day. On its return, it was found that a portion had been removed.*

Section V.—*The Unrecovered Washing.* This naturally aroused the suspicions.* A research was made, and it was subsequently found in a Russian monograph which neither of us could read.

Section VI.—*The Hard-boiled Egg and the Garibaldi Biscuit.* The deductions we were able to draw were few. There are so many kinds of hard-boiled eggs. We concluded that the lumps in a Garibaldi biscuit were not always flies. (Kjeldahl's method.)

Section VII.—*Who we are.* [We've had that already.—ED.]

Section VIII.—*Our thanks.* We wish to offer our respectful thanks to the Wardmaids of Guy's Hospital, to Mr. Betts' pigeons, the London Necropolis Company, and the Inspector of Nuisances for kind enquiries and sympathy. No flowers by request.

Section IX.—*Our conclusions*—

(*a*) A rolling stone gathers no moss, but may produce hæmaturia.

(*b*) People who live in glass houses should not pass stones.

(*c*) Half a loaf is better than no bread, except to a diabetic.

(*d*) Still waters run deep and have a high specific gravity.

Section X.—*References.* A. B. C. Time-table; "Good Words" (Volume II); and the "Adventures of a Doctor in Khaki," copies of which may be obtained from the author. [Advt.]

THE CARRION CROW.

The Smoking Concert.

ON Saturday, February 15th, in the evening, the Residents held a most successful Concert in the Dining-hall. Again we were surprised by the wealth of local talent. The most noticeable feature was the excellence of the until then unknown performers, at least to most of us. Mr. Wylie opened the entertainment with a pianoforte solo, and was followed by Mr. Parrott who sang "Gipsy John." No words of ours are needed to describe their respective "turns" as their merits are so well known. Of the instrumental part of the programme, the banjo trios (Messrs. Ellis, Taylor and Cook) were distinctly good, while Mr. Black with his bassoon quite brought the house down. Mr. Winkworth gave a 'cello solo in his characteristic style, and was deservedly encored. Mr. Camps and Mr. Plummer sang well and earned hearty rounds of applause. Mr. R. Ellis was quite good in his musical sketches and we hope soon to hear him again. Mr. Ray Edridge gave excellent renderings of one of the "Voces Populi" and the "Shut Eye Sentry." Mr. Wacher sang "Archie" in his inimitable manner. The encore verse, which was specially written for the occasion will, we are sure, live long in the Charity. Mr. H. M. Woodward held the audience enraptured while "he told them so." God save the King, brought an end to a most enjoyable evening, and we can only hope that this concert is but the beginning of a series of such successes.

Chapel News.

PREACHERS IN CHAPEL, MARCH 1—15.

Sunday, March 2.—Rev. W. J. Conybeare, Chaplain to the Archbishop of Canterbury. Rev. H. Ridley, Charterhouse Mission.

Sunday, March 9.—Rev. W. G. Boyd. Rev. W. J. Conybeare.

Wednesday, March 5.—Rev. E. F. Russell, S. Alban's, Holborn.

Tuesday, March 11.—Rev. W. W. Hough, Secretary, Rochester Diocesan Society.

Nursing News.

Matron's Office.

On the 19th inst., Miss A. R. Field, who entered the Hospital as a Probationer in September, 1898. was appointed Probationary Sister of the Isolation Wards. Probationer Guthrie has been appointed to succeed Miss Field as Head Nurse in Astley Cooper Ward.

Nurse S. A. Hayward, Head Nurse in Cornelius Ward, left the Hospital on completion of her three years' training, to take up her duties on the Private Nursing Staff. Nurse Boyle has been transferred to Cornelius, and Probationer Ray appointed Head Nurse in the Isolation Wards.

Mrs. Strathern who, since September, has been acting as temporary Night Sister, and Sister of Stephen Ward left the Hospital on Wednesday.

Miss Creighton, who has been in South Africa for the last two years, returned to the Hospital on the 26th inst., and took up her duties as Sister of Stephen, her former ward.

Notices.

FINAL F.R.C.S. ENG. EXAMINATION AND UNIVERSITY DEGREES IN SURGERY.

A six weeks' course of classes in the following subjects will commence on April 1st next:—

Clinical Demonstrations.—L. A. Dunn, M.S. Lond.
Operative Surgery.—F. J. Steward, M.S. Lond.
Surgical Pathology.—J. H. Targett, M.S. Lond.
Surgical Anatomy.—C. H. Fagge, M.S. Lond.

Four Afternoons in each week are set aside by the Surgeons of the Hospital to be devoted to Clinical teaching.

Candidates joining the above classes are admitted thereto.

The Fee, inclusive of Operative Surgery, is £15 15s.

Further particulars may be obtained on application to the Dean, Guy's Hospital, London Bridge, S.E.

ROYAL COLLEGE OF PHYSICIANS OF LONDON
AND THE
ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Diploma in Public Health.

Notice is hereby given that on and after the 1st of January, 1903, the fees for admission to Parts I. and II. of the Examination for the Diploma in Public Health will be increased from five to six guineas each, and that the same fee will be payable on re-admission to either part of the examination.

FREDERIC G. HALLETT, Secretary.

UNIVERSITY OF LONDON

"Rogers Prize," 1903.

Under the Will of the late Dr. Nathaniel Rogers, the Senate offer a Prize of £100, open for competition to all the members of the Medical Profession in the United Kingdom, for an Essay on "The Production of Immunity in Specific Infective Diseases—generally, and with particular reference to any one Disease on which the writer of the Essay may have made original investigations."

Essays, by preference typewritten or printed, must be sent in not later than February 28th, 1903, addressed to the undersigned,

PERCY M. WALLACE, M.A.,
Secretary to the Senate.

February 21st, 1902.

SOCIETY OF APOTHECARIES OF LONDON.

Notice is hereby given that on and after the First of January, 1902, the fee for the Licence will be raised to Twenty Guineas.

This notice does not apply to Candidates who entered under the old regulations.

These candidates will continue under the Regulations under which they entered.

FRANK HAYDON, L.R.C.P. (Lond.),
Secretary to the Court of Examiners.

June, 1901.

Prize Examinations, 1902.

Competition for the undermentioned Prizes will take place on the following dates:—

The Arthur Durham Prizes for Dissection.—Monday, March 10th, 10 a.m.

Junior Prizes for General Proficiency.—Wednesday, March 19th, 10–1, Elementary Anatomy; 10–1, Anatomy; 2–5, Physiology. Tuesday, July 22nd, 10–1, Histology.

Michael Harris Prize in Anatomy.—Wednesday, March 19th, 10–1. The date of the Practical Examination will be announced later.

Wooldridge Memorial Prize in Physiology.—Wednesday, March 19th, 2–5. The date of the Practical Examination will be announced later.

Senior Prizes for General Proficiency.—Wednesday, March 19th, 10–1, Clinical Medicine; 2–5, Medicine. Thursday, March 20th, 10–1, Clinical Surgery; 2–5, Surgery. Friday, March 21st, 10–1, Public Health. Monday July 21st, 10–1, Pathology; 2–5, Midwifery and Diseases of Women. Tuesday, July 22nd, 10–1, Pharmacology and Therapeutics; 2–5, Mental Diseases. Wednesday, July 23rd, 10–1, Medical Jurisprudence.

Beaney Prize in Pathology.—Monday, July 21st, 10–1. The date of the Practical Examination will be announced later.

Treasurer's Medals. — Tuesday, June 3rd, 10–1, Surgery; 2–5, Medicine. Wednesday, June 4th, 10–1, Commentary on a Case in Medicine; 2–5, Commentary on a Case in Surgery. Thursday, June 5th, 10–1, Clinical Examination in Medicine. Friday, June 6th, 10–1, Clinical Examination in Surgery. Operations to be announced later.

Golding-Bird Gold Medal and Scholarship.—Thursday, March 20th, 10–1, Paper; 2–5, Practical. Friday, March 21st, 10–1, Paper; 2–5, Practical. Saturday, March 22nd, 10–1, Practical.

Dental Prizes. — First Year's Students.—Tuesday, March 25th, 2–5, Anatomy. Wednesday, March 26th, 10–12, Physiology; 2–5, Dental Anatomy. Friday, March 21st, 2–5, Dental Surgery. Monday, May 26th, 9 a.m., Conservation Room Examination. Thursday, May 29th, 2 p.m., Clinical Examination. Saturday, May 31st, 9 a.m., Laboratory Examination. Second Year's Students.—Tuesday, March 25th, 2–5, Anatomy. Wednesday, March 26th, 10–12, Physiology; 2–5, Dental Anatomy. Thursday, March 20th, 2–4, Surgery. Friday, March 21st, 2–5, Dental Surgery. Monday, May 26th, 9 a.m., Conservation Room Examination; 2 p.m., Clinical Examination. Saturday, May 31st, 9 a.m., Laboratory Examination. Friday, June 13th, 9 a.m., Special Examination for Prize for Practical Dentistry. 1903 Prize.—Friday, July 25th, 2–5, Operative Dental Surgery (Paper). Tuesday, December 16th, 2–5, Dental Mechanics (Paper).

No Candidate will be allowed to compete for any Prize unless he has given notice in writing to the Dean at least *fourteen clear days* before the commencement of the Examination.

The Examinations for the Open Scholarships in Arts and Science will be held on September 23rd, 24th and 25th.

Guy's Hospital Officers and Servants' Dinner.

The seventh annual dinner took place on Monday, February 17th, at the Bridge House Hotel. The popularity of this dinner has been steadily growing from the first, and the last was certainly one of the most successful that has been held.

As on former occasions, Mr. Williams, the senior officer of the Hospital, presided; he was supported by the Treasurer and several of the Governors and Staff.

Dinner over, the loyal toasts disposed of, smoking became general, and everyone settled down to enjoy themselves.

Mr. F. H. Norman, as senior governor present, proposed the toast "Prosperity to Guy's." After referring to the splendid work done by the hospital, Mr. Norman described the great attraction medicine had for doctors and nurses, who could from day to day watch the results of their skill and care. He then passed on to point out that without fresh help the resources of the hospital could not keep pace with the numerous demands for improvement made by modern science, the ideal ward, whilst offering every comfort for the patients, ought to be made as uncomfortable as possible for the bacilli.

In response to this toast, Mr. Cosmo Bonsor explained that he was entirely under the control of the Chairman, who ruled him with a rod of iron in the Counting House and a bottle of champagne at the dinner. After telling an excellent story, the Treasurer concluded by saying he was sure all had the prosperity of Guy's at heart, and would do their best for such a great institution.

Mr. A. C. Cole proposed the next toast, "The Medical School." He pointed out that in the possession of a flourishing dental school Guy's as a general hospital occupied a unique position.

The Dean, in replying, said as a child he had always been taught that little people should be seen and not heard, his present wish was that he need only be seen. He had not been born an orator, and his dinner felt as if it had got down into his boots. However, this did not prevent Dr. Fawcett from making a capital speech, in which he showed how absolutely essential the school was to the hospital.

Lord Henry Bentinck proposed "The Treasurer's Health." Although he had only been recently connected with Guy's, his short experience convinced him that Mr. Bonsor possessed every quality essential to a successful and popular treasurer.

Mr. Allport responded for the visitors, making the wittiest speech of the evening. He drew a most pathetic picture of a G.P. driven to desperation by unpaid bills and a dispenser down with measles, running up to the "Dear old place" to drown his misery in fresh memories of a happy but misspent youth. Mr. Allport then described how changes meet the woebegone G.P. at every turn. Hotel Metropoles springing up like mushrooms in old corners, but the familiar forms of Chivers and others shone out in this desert of alteration like an oasis and cheered the heart of the despairing G.P.

In the absence of Sir Charles Fremantle, Dr. Perry proposed the Chairman's health in a brief but characteristically humorous speech.

During the evening the following gentlemen provided a most excellent musical programme:—Messrs. Larkin, Parrott, Fullerton, Baddeley, Wyatt, Dan Letto, Pittman, Edridge and Black.

"Auld Lang Syne" brought a most enjoyable evening to a close.

Passim.

Public dinners are only too frequently a torture in disguise, against which, even a contented mind born of good fare and a "Flask of wine" is not proof. But the annual dinner given by the Officers and Servants of the hospital at the Bridge House on February 17th, was from start to finish a thorough success. The small army that sat down to dinner revealed in an entirely new and forcible manner the hugeness of this "Great Institution." When showing visitors round we are accustomed to explain in a lordly and off-handed manner that Guy's is verily a town in itself, but without realising the full truth of our words—long residence has dulled our amazement. The after-dinner speeches were brief, and is not brevity the soul of wit? Undoubtedly the bonbouche of the evening was Mr. Cosmo Bonsor's carefully treasured announcement that in the near future the Prince and Princess of Wales intend making a surprise visit to Guy's, so that they may see it wearing its work-a-day garb. Poets from the "Good old days of Adam" have asked:—

"What were revel without wine?"
What were wine without song?"

and certainly the capital programme provided materially helped to make the evening the success it was.

The criticisms of our correspondent on the surgical side of the museum are, in the main, justified by the present state of that collection. For a long time past the arrangement has been badly behind the times, and the catalogue almost worse than useless. The whole of this section wants thoroughly weeding out, many new specimens to replace those that have spoiled through age, and above all, an up-to-date nomenclature and catalogue. Of course, it will come in time, but at present, men who are reading for examinations would save time by going elsewhere, seeing the difficulty there is in finding specimens, and still more, in finding descriptions of them. The medical specimens are, of course, splendid, the arrangement excellent, and the descriptions in the catalogue, models of conciseness. We believe also that the obstetrical section is undergoing great improvements. The surgical collection is, however, no credit to our museum. To re-arrange the specimens and to re-write the catalogue in a manner that would compare with the medical section, would, of course be a lengthy process, but could not some provisional description and arrangement be made? If a certain number of the specimens were selected from the present collection and some of the many recent additions which are at present stored away were brought to light and described, it would be of inestimable benefit to men working for examinations. The collection need not be too large, consisting only of examples of the common results of disease, and need not interfere with the placing of the whole of the section in a state that would be a credit to the hospital.

To see ourselves as others see us is always interesting and sometimes as stimulating as a cold douche. In the Christmas number of the *New Zealand Weekly Press* there is a story, "Cupid in the Wards," the scene of which is laid in Guy's. With regard to the actual tale, it is enough to say that the hero, "a well-built, dark-haired young fellow, the merry audacity of whose look might well have set anyone in authority on the look-out for disturbance of conventional routine," is H.P. in Clinical, while the heroine, a girl with a "clear capable cast of countenance, thick dark chestnut hair, and a pretty though firmly-set mouth with dimples at the corners," is of course staff nurse in John. Given this data most will have no difficulty in filling in the details from their own experiences.

The writer depicts the hospital as "a vast new building, an interesting, rather intricate old one, a park, a court, a chapel, various dark and tall houses, used for official residences, and a detached edifice known as the 'Clinical House.'" The Clinicals' room is described as being used by the "House Physician for the time being, and by a few Clinical Clerks, who were in residence as students." Clearly to the eyes of the author, the Clinicals are quite a secondary consideration, in fact, later in the story they are

spoken of as "youths," given to refreshing themselves on quiet afternoons by making tea. To speak of that august and time-honoured function, "tea in clinical," as if it were a schoolboy feast, eaten in secret, is indeed, enough to make every Clinical, old and new, "shed a bitter tear."

In another column will be found an account of our latest smoking concert, which was a very successful affair. Mr. Wylie officially opened the ball, and during the evening made several unofficial remarks. Mr. Wacher moved the audience to laughter, Mr. Black moved us to tears, and Messrs. Gibson and Brydone moved the piano. All these artistes were heartily applauded. Mr. Lewin led the applause enthusiastically. The ladies of St. Thomas's Street were in league against us, and only a few of the most daring of the Junior Staff managed to be present. The evening terminated by Mr. Cutler thanking the chairman and the chairman thanking Mr. Cutler for thanking him.

The second round of the Rugby Cup-ties against London was a very close struggle, ending as it did in a drawn game, each side scoring a goal and a try. The weather was of the worst variety, rain falling all the time, and consequently correct passing was difficult. Neither McEvedy or Orpen were able to play, so Payne played inside three-quarter and Louisson took his place at half-back. It is easy to make excuses for failure to win, but the fault undoubtedly lay with the play of our forwards. The back division were of course handicapped by the alterations, but our pack requires considerable improvement if we are to make a better show for the remaining matches. Several of our forwards did not make up for their lack of work in the scrum by good play in the loose. They broke up slowly and made little attempt to get across and help the backs when our opponents had the ball. If an example is needed they might do worse than follow that set us by our opposing forwards in the first round.

At Chiswick, we met St. Bartholomew's in the second round of the Association Cup-ties and only effected a draw. We started the game one short and scored two goals before he arrived. Bart.'s also lost a man and scored during his absence. The first half of the game was fairly interesting, but the second was practically a pure defence of our opponents' goal, broken only by one attack which was nearly successful. The forwards passed moderately, but their shooting was execrable, and it was due to this that the game was not won. Many excellent chances were thrown away although it cannot be denied that the Bart's goal-keeper effected some brilliant saves.

After playing a drawn game of two goals each on February 20th, the Association team on Wednesday defeated St. Bart.'s in the second round of the Cup-ties by six goals to one. Barber scored the two first goals from excellent centres by Peall; Peall got the third from a corner, Litchfield ran down the right wing and scored the fourth, whilst Barber ran through and obtained the two last points. Their goal came of a mistake by the referee, the ball having previously gone out of play.

A few weeks ago we published a rumour that had reached us from the Cape, to the effect that one of Guy's men, Malim, was in all probability killed during the surprise effected by De Wet upon our troops at Tweefontein. Now, happily, we are in a position to refute it. Malim is safe, although not altogether sound, as he is recovering from the effects of enteric. He was in the field hospital at the time of the surprise and was afterwards transferred to Mooi River where two of our men, Tongue and Featherstone, were in charge. A correspondent has kindly informed us that he is now convalescent and is already on his way home.

The retiring editor of the *St. Thomas's Gazette*, in reviewing the part played by the paper in hospital life, speaks of the great difficulty experienced in getting junior men to come forward with contributions. His remarks might be read with considerable advantage by the younger men at Guy's. We are constantly being told that the life up here is hackneyed and

narrow minded, but it is a well recognised fact that a man's surroundings are what he chooses to make them. There is no need for the life of a big hospital to be cramped if only men would make the most of its many opportunities, and the Gazette might become more representative and widen its sphere of interest if the junior men would do their share.

A review of the last volume of our reports appears in the current number of the *Dublin Journal of Medical Science*, which although favourable is not altogether satisfactory, for we think that more care might have been taken in seeing that names of contributors were correctly spelt.

We would congratulate Messrs. Sime, Hirsch and Batty, all Guy's men, in obtaining the tenth, eleventh and thirteenth places in the recent entrance examination for the Indian Medical Service.

Whilst on the subject of the services, we notice that Mr. Charters Symonds has been appointed Surgeon-Lieutenant in the 4th County of London Imperial Yeomanry.

In accordance with the will of the late Mr. Brown, a course of five lectures on "The Protozoa in their Relation to Disease," will be delivered by J. Rose Bradford, Esq., M.D., at the University of London, South Kensington, on Tuesdays, February 25th, and March 4th, 11th, 18th and 25th, at 5 o'clock. These lectures are free to the public.

As we are going to press we have received the welcome news that Guy's defeated London in the replayed tie by 2 goals and 1 try to nil.

Novelties.

Messrs. Charles Letts & Co, have sent us samples of note books they are issuing at 1s.; with these books they include a coupon, insuring the owner for £100 against death from small-pox, together with an allowance of £1 a week during five weeks of the illness.

Medical Heresies.

A paper read before the Physical Society on January 29th, 1902, by Mr. Owen Richards.

Mr. President and Gentlemen,—When I was asked to read a paper before this society I was a good deal perplexed as to what subject I should choose. I did not wish to inflict on you a mere collation of text-books. For a paper on a medical subject which is entirely second-hand, runs a great risk of being very dull. And I found that my own small clinical experience contained scarcely anything which had not already been far more ably treated elsewhere.

Finally it occurred to me that it might be of interest to you to hear something of those systems of medical theory and practice which are condemned by all orthodox and established schools of medicine, but which, nevertheless, have a considerable influence in the lay world.

For we are here, gentlemen, in a very stronghold of medical orthodoxy, and we are apt to treat these heresies with a violent and rather unintelligent contempt. Contempt they may possibly deserve, but any reasoned system which is accepted by any considerable body of men is at least worth understanding. We are better fitted to combat any error if we know the principles and fallacies which underlie it, rather than the jokes that people have made at its expense.

Now I do not propose to deal with any system which is primarily religious; there are many such, but they are not suited to discussion by a society of this kind. The two heresies which I propose to bring before you to-night are *Homœopathy* and *Christian Science*.

These are, both of them, reasoned systems of medical theory and practice; they make no appeal to the supernatural, they do not claim that their practitioners possess any power which may not be exercised by any man who takes the trouble to study and understand their principles. They lay the whole of their methods openly before the public, and by so doing they purge themselves of *Quackery*. For the essence of quackery is the claim by individuals to possess secret knowledge or powers which they keep secret for their own use and benefit.

I intend, then, to give you a short account of the origin, the principles, and the practice of these two heresies. For the sake of fairness I have drawn my information almost entirely from sources which they themselves recommend, and from the little I have been able to see personally of their methods. I am afraid the account will necessarily be rather sketchy and incomplete.

In conclusion I hope to say a few words about Quack medicines, which stand on an entirely different footing.

The first of these heresies in historical order is *Homœopathy*. Homœopathy was founded in 1796 by *Hahnemann*. Hahnemann was a Viennese doctor, who was very much dissatisfied with the state of medical practice at that time—which, indeed, left much to be desired. He felt this so acutely that he had given up his practice, and was earning his living by translating books and doing

work in chemistry. While he was thus occupied it occurred to him that it might be possible to arrive at some more accurate knowledge of the action of drugs by giving doses of them singly to healthy persons and observing the effects. This was a perfectly sound method of experimenting which apparently had been neglected. The tendency at that time was rather to deduce the action of drugs from general principles, or from authority, and to give them two dozen at a time in one mixture. His first trial was with *quinine*. He took several scruples of this in successive doses at a time when he was quite well. He was thrown into a feverish state which had some resemblance to the fever of malaria. This first suggested to him the theory, which he afterwards adopted, that diseases which are produced or simulated by large doses of a drug in healthy people are curable by small doses of that same drug in such people—just as malaria, which is produced or simulated in previously healthy people by large doses of quinine, is cured with some certainty in fever patients by small doses of quinine. He proceeds to test this hypothesis with other drugs, and he and others carried out a most laborious examination of the symptoms produced by large doses of almost all the known drugs of that period. These researches extended over many years and their results are embodied in certain large volumes called the Provings. The process of taking a dose of any drug and recording the symptoms which ensued was called the "proving" of that particular drug.

Unfortunately, these researches, which might have been of enormous value, are rendered nearly useless by the arrangement of the results. All the symptoms either produced by the drug, or simply following its administration, in the case of perhaps a dozen "provers" of different ages, constitutions and nationalities, are recorded indiscriminately; and arranged not under the names of those individuals who felt them, but under the name of the organ to which they were referred. Thus, if a drug caused headache in eleven cases and sneezing in one, headache and sneezing would be put down together under the title "head," with nothing to show that one was commoner than the other. Further, all the mental and moral conditions were recorded—that very common mental state of "desiring to do a good action, but not one of any particular kind," is attributed to a drug of which I have forgotten the name. The result is a welter of conflicting and insignificant symptoms; thus, to belladonna are attributed no less than 1440 symptoms of various kinds.

However, out of all the confusion came certain facts which confirmed Hahnemann in his hypothesis.

Thus, *belladonna* given in large doses produced a scarlatinal rash fever, and a sore throat, the clinical picture of scarlet fever. Hahnemann gave belladonna to scarlet fever patients and they subsequently recovered. He gave it to healthy people and they did not catch the disease when they were exposed to infection.

Rhus toxicodendron, or the poison oak, a drug not in the pharmacopœia, when given in large doses, produced symptoms which were considered an epitome of typhus or typhoid fever. In small doses the sufferers from these diseases took it and subsequently got well.

Aconite in the same way simulated and cured "simple inflammatory fever," which I take to be septic fever. Incidentally, one prover died of aconite poisoning.

Equally gratifying results were obtained with *perchloride of mercury* in dysentery, and many other drugs could be cited. In this way, Hahnemann was led to develop his scheme of medicine, which consisted essentially in observing the symptoms produced in healthy people by large doses of single drugs, and giving these drugs in small doses to cure diseases which presented similar symptoms. This principle was embodied in the motto—"Similia similibus curantur."

The doses at first were small, but not minute. For some time Hahnemann gave the usual doses, and some of his followers insist that the principle of homœopathy is independent of any question of dosage.

However that may be, Hahnemann himself soon adopted the system of minute doses, and explicitly embodied it in his creed. This came to pass in the following way. Hahnemann was confronted with the difficulty that fair-sized doses of many drugs only aggravated the symptoms which they were designed to cure. Thus, cantharides produces symptoms resembling "strangury," which I take to mean a spasmodic stricture. Yet when a fair dose of cantharides was given to a patient suffering from strangury, it not only failed to cure him but increased his sufferings enormously. In fact, a century before homœopathy was ever heard of, one Greenfield—a member of the College of Physicians—was sent to Newgate for malpraxis by the President of that College, because he had given cantharides to a patient suffering from this complaint. Similar disasters followed the use of many other drugs which were theoretically indicated.

Hahnemann met this difficulty by saying that when drugs are given in large doses we get their gross physical effects, whereas when they are given highly diluted we get their hidden remedial power. This change was due to the fine division of their particles, and he instanced the difference between metallic mercury given in its natural state and the same metal given minutely divided, as grey powder. He contended that the rubbing or shaking by which the drugs were divided or diluted developed their properties as remedies. This process of division he therefore called *dynamization*, and the resulting solutions he called progressively *higher potencies* of the drug.

These dilutions were very considerable. The mother tincture from which they were made was of the same class as the B. P. tinctures, sometimes stronger, sometimes weaker. Of course many of the drugs are not pharmacopœial.

The dilutions are arranged on a decimal scale. Thus, the first dilution would be a 10 per cent. solution of the mother tincture, the second a 1 per cent., and so on. Hahnemann recommended the thirtieth dilution or

potency for routine use. The percentage of the mother tincture contained in this would be represented by a decimal point followed by 26 noughts and a 1. Thus:—·00000000000000000000000001. It is to be remembered that the tincture is only a solution of varying strength of the drug, and that the medicine would be given in doses of a few drops in a tumbler full of water.

In the same way solids were diluted with lactose. After the sixth dilution with sugar it was found possible to dissolve them all in water—at any rate metallic mercury of this dilution gave no undissolved residue. In the same way solutions of lead, copper, platinum, zinc, and other bodies not readily soluble in water were prepared. The subsequent higher dilutions presented no difficulty.

Armed with these drugs the homœopathists soon found proof of their value.

In 1836 the Asiatic cholera attacked Vienna. All the hospitals were filled, and filled under pressure, so that there was probably no selection of cases. The allopathic mortality was 66 per cent., the homœpathic only 33 per cent. The homœopathic hospital was presided over by an allopathic doctor, who seems to have "covered" the avowedly homœopathic treatment. This remarkable result produced a great sensation, and as a result the Emperor removed the restrictions which had previously been placed on the practice of homœopathy and placed the hospital on an equal footing with the others, so that "covering" became unnecessary.

The results continued to be extremely good. Statistics are rather confusing, it will be simplest to take those of one fairly definite type of disease, *pneumonia*.

In a series of 1,134 cases of this disease admitted to the orthodox hospital at Vienna, there was a mortality of 23 per cent.

In a series of 538 cases admitted during the same period to the homœopathic hospital there was a mortality of 5 per cent. That is to say, that on the face of these figures there were more than four times as many deaths under the old treatment.

The homœopathists found the explanation of these results in the efficacy of their medicines. The real explanation would seem to lie in the very drastic treatment which these cases received at the hands of the orthodox physicians of that time. It was an epoch when calomel, tartar-emetic, blistering and bleeding were the routine treatment of most diseases. A good deal of light is thrown on this point by the experiments of an orthodox physician of about that date, Dr. Dietl of the Wieden Hospital, Vienna. Dr. Dietl treated a series of 380 cases of pneumonia during three years—85 were treated by repeated bleedings, with a mortality of 20 per cent.; 106 were treated with tartar emetic with a mortality of 20·7 per cent. the remaining 189 were treated simply by diet, without any medicine; the mortality among these was only 7·4 per cent.

Thus we have the result that treatment by either of the two orthodox methods then in vogue, in a definite disease of easy diagnosis, like pneumonia, gave a mortality of over 20 per cent. Nursing, without treatment, or with homœopathic treatment, gave a mortality of less than 8 per cent. It is impossible to avoid the conclusion that the orthodox drastic treatment was responsible for a mortality, an additional and avoidable mortality of 12 per cent.

What the homœopathists did was to save men from this danger and let nature have a fair chance. Their treatment probably differed more in form than reality from the modern expectant treatment. At any rate, results like these caused a rise and spread of homœopathy all over Europe. The medical trades unions of the time, the colleges and universities, persecuted its practitioners, denied them degrees, boycotted them socially and professionally, expelled them from towns. As orthodox medical practice improved this acrimony died away, the orthodox doctors learnt what homœopathy could teach them, the homœopathists learnt to reject the more mystical and extreme parts of Hahnemann's teaching, and the treatment of both is to-day surprisingly alike.

Modern homœopathic treatment is seen at its best in the Homœpathic Hospital in Great Ormond Street. This is an extremely well equipped hospital, staffed by men from Guy's, Thomas's, and the other big hospitals. The surgical side is much what the surgical side of Guy's would be if we had a good deal more money and rather less work, a splendid theatre, and bright, clean, roomy wards, with cases of hysterectomy, pylorectomy, excision of the rectum, and all maner of other operations, doing, as far as one could see, extremely well. The antiseptics used are biniodide, lysol, and carbolic in the usual strengths, there is no question of dynamizing them to a higher potency.

On the medical side the differences are more apparent than real. In a case of enteric, for instance, the case is taken and written up in the usual way; no stress is laid on subjective symptoms at the expense of physical signs. If necessary, the diagnosis is helped by a series of Widals. The patient is carefully nursed, and probably some drops of a high dilution of *Rhus toxicodendron* are given in water every few hours. I do not think any objection can be made to this, Osler expressly says that water should be given freely in this disease.

On the other hand, when a case really requires drugs, the drugs are given, and in effective doses. Ergot, potassium iodides, iron, even sodium cacodylates, and many other active drugs are given, at times, in what we should consider full doses.

Naturally the practice differs in detail from ours, sodium salicylate in acute rheumatism is replaced usually by *agaricus*, which I imagine contains a trace of *muscarin*, and morphia is only given reluctantly.

But speaking generally, the cases which do not need active treatment receive high dilutions of rare drugs, to which their cure is attributed. Cases which need drugs get them.

For anyone who wishes to amuse himself at the expense of homœopathy there is ample material. The Provings are very funny reading, and Hahnemann in his later

years became increasingly fantastic and mystical. From absurdly high potencies he progressed to recommending the method of smelling a solution of the desired drug. He talks of homœopathic treatment of one disease by another; of combating emotions by small amounts of similar emotion artificially produced. Thus, the soldier alarmed by the cannon's roar, is fortified by the beating of a drum, that is to say, by a small dose of a similar noise. The cries of the wounded are meanwhile robbed of their terrors by the shrill scream of the fife. He finally loses himself in the quagmire of animal magnetism.

But amongst all this nonsense we must not lose sight of the great services which the homœopathists have rendered us. At a time when drugs were given in mixtures of 20 or 30 they began to give single drugs, they instituted experiments to define the action of each drug, and they gave them either for a definite reason or not at all. They freed us from a most painful and dangerous system of treatment. Their experiments were inaccurate and badly recorded. They took no account of anything but symptoms. Their main idea was unsound, their writings were as windy as their medicines were watery, but for all that they were the pioneers of a rational system of therapeutics.

Christian science—so-called—is a very different matter, and has even less to do with science than with Christianity. But it deserves our consideration here to-night, because it possesses a body of between three and four thousand qualified practitioners, who are prepared to treat all and every kind of ailment for money, and to the exclusion of the medical man. Further, it is not a "quackery," for its professors claim that anyone who really understands the method and the text-book can perform cures. And both are for sale—at exorbitant prices it is true—but still in the open market.

The founder and head of this heresy is an American woman, *Mrs. Mary Baker G. Eddy*. We learn from her autobiography that as a child she was intensely and emotionally religious; before she was twelve years old she heard supernatural voices calling her, like the infant Samuel. At the age of twelve she suffered so severely from doubts about predestination that she became feverish and was attended by a doctor. However, on recovery, she made such a moving profession of faith in the chapel, that she tells us she was kissed by many of the elder members of the congregation.

In due course she was married to a Mr. Baker. Left a widow by his death from typhus she married again and became Mrs. Glover. When she was about 40 (the age at which Mahomet began his mission) she had an internal injury following an accident. She recovered from this, and regarded her recovery as a miracle. She then retired from the world for three years, she tells us, "to ponder her mission, to search the Scriptures, to find the Science of Mind." At the end of this time, in the year 1866, she discovered "Christian Science." In 1875 she published a book, which is still the text-book of the sect, called "Science and Health, with a key to the Scriptures." She formed an organisation of six members in 1876; in 1877 she married her first pupil and her third husband—Mr. Eddy; and in 1879 the "organisation" became a "church." Two years later she founded the Massachusett's College of Metaphysics at Boston, and there taught the art of healing. The fee for each student was £60 for a course of three weeks' tuition, and there was no lack of students. Finally, for no apparent reason, College and Church were dissolved, but the Church, at any rate, continued to flourish. Mrs. Eddy, now left a widow for the third time, is an object of veneration to the whole sect, and is probably a very rich woman. The sect contains three to four thousand qualified practitioners, is composed almost wholly of rich and leisured people, and shews at present a slight tendency to spread among this class both in England and America. I propose to give you a slight sketch first of the doctrines and then of the practice of this sect.

The doctrines are wholly contained in the book, "Science and Health," which is sold plainly bound, at 17/6 a copy. Portions of this are read at the meetings of the sect, alternately with extracts from the gospels. It is the only authorized text-book, though its author is prepared to allow that "a few books, based on this book, may be useful." She warns the reader that "although this volume contains the complete science of mind healing, never dream that you can absorb its whole meaning by a simple perusal; it needs to be studied."

The book contains 600 pages, and is one of the most obscure books imaginable. It is full of luxuriant sentences which sound as if they meant a great deal, but which really mean nothing of any importance. The whole is still further obscured by a copious misuse of metaphysical and scientific terminology. Mrs. Eddy admits that "the petty intellect may be alarmed by constant appeals to Mind." She spends two-thirds of a page in defining mortal and divine Mind, her definition contains no less than 38 abstract nouns, and no verbs at all. The petty intellect may well be alarmed at a word which is usually spelt with a capital letter, and whose meaning is still doubtful after 38 abstract nouns have been used to elucidate it.

The religious system need not detain us, it is practically Christianity with the driving power left out; a selfish Christianity in which all the inconvenient features are cut away, and a Bible which is only to be studied in the light of Mrs. Eddy's key to the Scriptures.

Mrs. Eddy claims that Christ's miracles of healing were not supernatural, but were the result of scientific knowledge, knowledge which was then hidden from the world for many centuries, till she herself re-discovered it by a study of the Scriptures.

This discovery may be stated as follows:—

(i.) All that we know of the universe we know through our senses. Our life and knowledge consists wholly of sensations. What we call *matter* is simply certain kinds of sensation.

(ii.) Sensations are always misleading. No reliance can be placed on them at all.

(iii.) The existence of sickness and evil is inconsistent with the goodness of God. And since the only evidence we have for their occurrence is sensation (which is unreliable), therefore they do not exist. The sensations we call sickness and evil are due to the errors of mortal mind, and as soon as we realize this they cease to exist.

The proof of this lies in the marvellous cures effected by Mrs. Eddy's method. The method consists simply in the patient fixing his mind on the logical impossibility of the existence of disease. The qualification of the practitioner consists in having a thorough understanding of these arguments and conclusions, and his work is to make them clear to the patient by argument, repetition, or simply by his presence. As soon as the falsity of the sensations, which the patient calls sickness, becomes apparent to him, the sensations themselves, convicted of lying, take to flight and disappear. This is a process quite distinct from faith cure: it is a logic cure, a cure by the use of the understanding. This is the Christian Science system as fairly and shortly as I can state it.

(*To be continued.*)

Types.

No. V.—The Man from South Africa.

"Why, 'tis a gull, a fool, a rogue, that now and then goes to the wars, to grace himself, at his return into London. And such fellows . . . . will learn you by rote where services were done."—*Shakespeare.*

Scene.—*The Clinicals' Room.* Several men scattered round a large oak table discussing the latest diagnosis and tea. An eminent physician of world wide reputation, stands with his back to the fire and discourses on treatment with the aid of a teacup and a bit of sultana cake. An odour of clinical research emanates from an evaporating basin.

Enter the Hero. *He is attired in spotless khaki and swings in with the air of a pantomime swashbuckler. He salutes the company with easy grace and upsets the teapot.*

Polite Clinical. Er, do you want to see anyone? Have some tea.

Hero. Thanks. Don't you men know me, I'm X——, one of the Deelfontein dressers y'know. I only landed yesterday and havn't got my papers yet so I've got to wear this beastly khaki (with an admiring glance at a bran-new pair of puttie leggings) I fancy—

Physician (speaking in level monotonous tone). And I have found that Shoetopsky's treatment with micromilligrams of digitoxin in typhoid—

Hero. Talking of typhoid, you chaps should have been out in South Africa. I had four wards under my care. Cases used to come in and die like flies. You don't see anything like that here.

Chorus (fervently). Thank Heaven!

Physician (once more becoming audible). And in the Archives Von Vomitsplotzen you will find—

Voice Without. Clinical for the week in front surgery, please.

Hero. Talking of the front, you should have seen how some of those chaps of ours used to get in the wounded. They took advantage of every stick of cover y'know. (He proceeds to turn the biscuit tin's position by a masterly flanking movement which includes the coal-box, the table, and the physician's legs).

Physician (regarding these movements without the faintest show of interest). As an illustration to my remarks, I might say that I was called in consultation—

Hero (beaming). There wasn't much need for a consultation when a Tommy knocked up against a pom-pom, I can tell you. The first one I saw put ME off my scoff for a day.

Ingenuous Clinical. Did you see much service when you were out there?

Hero (laughing with the assured ease of a tried soldier). Why, my dear fellow, when De Wet—— (Stops suddenly as door opens and a tanned smiling face appears. Everybody gets up and hails the newcomer with delight. The physician even forgets to vapourise.)

Newcomer. Hullo X——, you all right again now? Rough luck on you getting sick before you even landed. You came home in the boat you went out in didn't you?

[A silence, in which the curtain slowly falls.]

THE OWL.

From the Gazette's Special Pathologist.

H.R.M., Hastings.—No tubercle bacilli were found in this specimen.

PATHOLOGIST.

Reviews.

The price of books submitted for review should in every case be stated.

Human Embryology and Morphology. By Arthur Keith, pp. 324, illustrated. (Edward Arnold, London.) 12s. 6d. nett.

From the preface we learn that this short account of the development of the human embryo is founded upon a course of demonstrations given at one of the larger London medical schools, and is intended primarily for the use of medical students. Further, the relative importance of the various parts of the subject dealt with has been largely determined by their power of being subsequently applied to the explanation of facts in the different branches of medical study. The book is therefore written with a definite object in view, which it fully attains. We know of no book on human embryology which is at once so full, so clear, and so directly useful to the medical student. It is not too much to say that a careful perusal of it would repay anyone whether in the dissecting-room or in the wards.

The subject is dealt with in a purely dogmatic way and discussions on divergent views are for the most part omitted. Comparative anatomy is introduced only when it is essential to the understanding of structures in man. A perusal of the book is, however, the most convincing argument we know that even the smattering of comparative anatomy which the average medical student is still obliged to learn, enables him to understand important points in anatomy and surgery which he otherwise could not.

A fleeting knowledge of the fœtal circulation and membranes, with the addition of the centres of ossification of some bones, which together form the embryological stock in trade of many students, is at best a sorry selection of the subject. In this book he has placed in his hands an account of the important parts of the whole subject and in a form which requires but little previous knowledge to understand. The numerous original illustrations which explain every detail referred to in the text, deserve more than a passing word of praise.

We notice with pleasure the excellent accounts given of the development of the organs of special sense and of the central nervous system and the cranial nerves; parts, the anatomy of which is easy to understand, if their development is studied at the same time. Further, in dealing with the limbs we are glad to see that special attention is drawn to the results obtained by the investigations of Sherrington and of Head into the segmental supply of muscles and skin by the special roots; a knowledge of which is just as important in medicine and surgery as a knowledge of the supply of the same structures by the peripheral verves.

Sport.

Rugby Football.

GUY'S v. KENSINGTON.

Played at Honor Oak Park on Saturday, February 8th, 1902. Guy's kicked-off, and Kensington returned well into touch. Play settled down in midfield and consisted mainly of a scramble between the rival forwards, in which neither side showed to much advantage. About twenty minutes from the start, Alcock received the ball, and after fending off the opposing full-back, scored in his own inimitable style; the kick failed. Play of an interesting character ensued. Half-time, Guy's, 3 points; Kensington, nil.

Soon after resuming, Guy's began to press, and Morgan dropped a goal from a mark. Later, Wall following up well, dribbled, and scored well out; the attempt at goal again failed. Kensington began to press towards the end and looked certain scorers, when the right centre dropped the ball, Alcock secured, raced down the field and scored between the posts; major points were added by Morgan. Result, Guy's, 15 points: Kensington, nil.

REMARKS.—The muddy condition of the ground probably accounted for the uninteresting character of the play. The attack of the backs appeared to lack sting. Some of the forwards gave little if any assistance, either in the loose or scrum. Team:—

GUY'S.—R. D. Bridger (back); E. Morgan, A. O'Brien, F. E. Walker, F. Alcock (three-quarter backs); O. V. Payne, M. C. Wetherell (half-backs); H. A. Cutler, R. C. Lawry, D. H. Trail, A. H. E. Wall, E. H. B. Milsom, A. R. Thompson, O. M. Tolhurst, E. M. Saunders (forwards).

GUY'S v. CROYDON.

The return match against Croydon was played on our opponents' ground last Saturday. The weather was all that could be desired, but the turf a little slippery.

Croydon kicked-off twenty minutes after the advertised time, and Harrison returned into touch. From a scrum the ball was passed out to their three-quarters, and the wing man kicked well into our twenty-five, from which Morgan dribbled back to half-way. From a scrum, the Croydon forwards got away, but were well stopped by Orpen. Both packs appeared fairly even, but our eight secured the ball oftener, and led by Cutler, Ward and Lawry, invaded the Croydon twenty-five. They were checked by Trollope, who found touch near half-way. From a scrum, Louisson passed to O'Brien, and he to Orpen, who was tackled; immediately afterwards, however, some fine passing by our three quarters, ended in Morgan scoring a splendid try, which was converted. From the kick-off Harrison returned to half-way, where Anderson stopped a dangerous rush, and Morgan tackled well. The Croydon halves then passed out and the three-quarters got away, but Rushworth was well tackled by Alcock before he got into his stride. The Guy's forwards

now combined better, and Saunders was prominent in some loose rushes; we were stopped by Trollope, who relieved with a well-judged punt. Several really good forward rushes were spoiled by one or two of our forwards kicking much too hard—the sooner we realise it is much to our disadvantage to kick too hard, the better. The ball was again transferred to our three-quarters who passed very well, and Morgan, before being tackled, returned to Orpen, who scored a really pretty try wide out. This Harrison failed to improve. Their drop-out was taken by Morgan, who found touch near the goal-line. From a scrum the ball reached Alcock, he broke through, and passing unselfishly, enabled Louisson to score; Morgan converted. Our forwards were still holding their own, but the halves passed a little wildly. On one occasion a Croydon three-quarter intercepted and nearly scored. Half-time was now called with the score 2 goals and one try in our favour.

Milsom started the second part for us. The ball was passed out to the Croydon third line, and, although they passed prettily, they were unable to make much headway. The Croydon forwards appeared to have more control over the ball in the open than our eight, and brought off some dangerous rushes, which were well stopped by Orpen and Alcock. Several of our forwards seemed to have forgotten that it is quite useless tackling a man high, and they lost much ground consequently; forwards who tackle low will find that the opposing backs will rarely regain the ground won by a rush. For off-side, Croydon were awarded a free kick, but Coall was unable to place a goal. Some loose play followed, in which Wetherell and Saunders were conspicuous. Again, however, the kicking was too hard, and a touch-in-goal resulted. The game now became more open, and our forwards heeled-out well, the three-quarters took full advantage of this, and after excellent passing, Morgan scored again; no goal followed. The same player added two more tries in rapid succession by clever runs, in fact he appeared at his best. Both the tries were improved upon, and no-side was called with the score 3 goals and 3 tries (24 points) in our favour. Team:—

Guy's.—E. M. Harrison (back); F. Morgan, A. O'Brien, F. Alcock and L. J. J. Orpen (three-quarter backs); M. C. Wetherell and M. G. Louisson (half-backs); H. A. Cutler, R. C. Lawry, A. R. Thompson, B. Glendinning, R. G. Anderson, E. L. Ward, E. H. B. Milsom and E. B. Saunders (forwards).

Mr. Gunnery acted as referee.

GUY'S v. LONDON.

Inter-Hospital Rugby Cup.—Second Round.

This match which was postponed owing to the frost the previous week was played at Richmond on Monday, February 24th, in wet weather.

Guy's had McEvedy, T. P. Thomas and Orpen off through illness and injuries. Payne therefore played centre three-quarter, Louisson half, and Saunders forward. Winning the toss, Cutler elected to play downhill in the first half. The wind, which was slight, blew across he field. From the kick-off, London pressed, and having the better of the scrums their three-quarters attacked, but Payne was conspicuous for some excellent tackling, whilst Morgan and Harrison kept their lines intact by judicious kicking into touch. Our forwards then commenced to obtain possession more often, and some passing between our backs resulted in Alcock and Morgan almost getting in, the latter once being sent into touch within a few yards of the goal-line. The same player also made two good attempts to drop a goal. Eventually the ball was sent out to O'Brien, who drew the opposing backs well on to himself, and then passed to Morgan, who got over; the same player landing a neat goal. For the rest of the first half play was very even, though the London forwards obtained the ball more often than we did, and their backs, especially Crimp and Gibson, made some excellent attempts to score, but our defence was very sound, and at the interval Guy's led by 1 goal (5 points) to nil.

Resuming, London attacked, their forwards bringing off some excellent dribbles, and within ten minutes a round of passing by their three-quarters resulted in Gibson making a splendid run; he was missed by three men and succeeded in grounding the ball between the posts. The major points were obtained, thus bringing the scores level amidst great excitement. Play was then keener than ever, and our forwards dribbling well, brought play into the London twenty-five. Here a long series of scrums took place, but at last Louisson obtained possession, and passing to O'Brien, that player again gave Morgan a good opening, which resulted in a try in the corner; the goal-kick by Morgan just failed. From the drop-out, Harrison let the ball go into touch, and London again attacked, but Guy's retaliated, and excellent passing resulted in Morgan again getting over, but the try was disallowed, the touch-judge considering that he had gone into touch about ten yards from the line. Again attacking, London scored, and Iles just failed to convert rom a rather difficult angle—the scores again being level. Harrison made a good attempt to drop a goal whilst going full speed, and Morgan also made two very good runs just before time was called, but in each case he was well tackled by the full-back. Result:—

Guy's—1 goal 1 try (8 points).
London—1 goal 1 try (8 points).

Guy's.—E. M. Harrison (back); E. Morgan, A. B. O'Brien, O. V, Payne, F. Alcock (three-quarter backs); M. C. Wetherell, M. G. Louisson (half-backs); H. Cutler (capt.), R. C. Lawry, A. R. Thompson, B. Glendinning R. S. Anderson, E. H. B. Milsom, E. L. Ward, G. M. Saunders (forwards).

Referee: —. Harnett, Esq.

Touch Judge: Mr. Tom Morgan.

Association Football.

GUY'S v. EWELL.

This match was played a Ewell on Saturday, February 1st, in a high wind. Winning the toss, the Hospital played down the slope with the wind behind them and had the better of the game. Our right wing worked well

and sent in several good centres, but the shots went high over the goal with the wind and good opportunities were missed. Our opponents became dangerous at times but the backs cleared well. Nothing was scored in the first half, and on changing over, Ewell attacked vigorously but failed to score owing to wild shooting. The game was fairly even till a quarter of an hour before time, when Barber dribbled through and scored with a hard shot. Shortly after this, from a pass by Wragg, Barber again dribbled pass the backs and scored, and a few minutes before time added a third after a good run, and the game was a victory for the Hospital by three goals to nil.

The halves and backs played a sound game, and Wragg at outside right was in good form, while Barber in the centre scored the three goals with fine shots. Team :—

H. D. Wyatt (goal) ; T. Edey, A. R. Wilson (backs) ; N. C. Marten, A. Denning, L. H. Frankenburgh (half-backs) ; E. Wragg, H. Berry, H. Barber (captain), E. L. Norton, P. A. Peall (forwards).

GUY'S v. REIGATE.

This match was played at Reigate on Saturday, February 22nd. The ground was in excellent condition, and the weather ideal. Winning the toss, Guy's played up the slope, and the game at once became fast, our opponents having most of the play, but their shooting was rather wild. After the first ten minutes, Guy's played harder, and repeatedly attacked the Reigate goal. From a long passing run of the forwards, Barber, when close to the goal, sent across to Norton and enabled the latter to easily score our first. At the close of the first half, Barber, by a fine piece of dribbling, sent in a good shot which gave their goal-keeper no chance of saving, and so the teams crossed over with the hospital leading by 2—0.

The second half saw Collins tested several times by good shots, which he cleared well on every occasion. The defence of our backs and halves was very sound, and our opponents were unable to score. From a kick of their left back the ball rebounded from Barber about twenty yards from their goal a few minutes before time, and by a high swift shot into the corner of the net he added the third goal. Neither side could score after this, and the hospital thus won a good game by 3—0.

The whole team played well, the passing amongst the forwards being good. Denning and Frankenburg at centre and left half respectively were untiring, and showed sound form, while the backs and goal-keeper were very safe. Team—

E. A. Collins (goal) ; T. Eady, A. R. Wilson (backs) ; R. C. Martin, A. F. Denning, L. H. Frankenburg (halves) ; P. C. Litchfield, H. Berry, H. Barter (Capt.), E. L. Norton, P. A. Peall (forwards).

GUY'S v. BART.'S

Replayed Cup Tie Second Round.

Played at Winchmore Hill on Wednesday, February 26th. Guy's lost the toss and played towards the sun and wind, on a heavy ground. Despite this, we had almost all the play and netted the ball four times before the interval. Two of these being disallowed, we crossed over leading 2-nil. Playing with sun and wind behind us, the play went even more in our favour in the second half, with the result that four more goals were added, while Barts.'s scored a very doubtful one against us.

Result :—Guy's, 6 ; Bart.'s, 1.

Remarks.—The goals were scored by Barber (4), Litchfield and Peall. The team as a whole played an excellent winning game, Barber being in great form. Denning played a magnificent game at centre-half, which seems to suit him better than the wing. On the season's form we ought to win the cup, if the men get thoroughly fit.

Pass List.

Final Conjoint Examination, January, 1902.

Medicine, Surgery and Midwifery.—*P. N. Blake Odgers, *L. Gifford Nash.

Surgery and Midwifery.—H. Davies-Colley, N. N. A. Houghton, D. H. Trail, G. T. Wrench.

Medicine only.—*H. Barber, G. B. F. Churchill, *J. Evans, *A. W. Gater, *H. A. Higgens, *C. R. Howard, G. F. Humphreys, *A. D. E. Kennard, *W. P. Ker, *S. S. H. Shannon, *A. H. E. Wall, *J. L. Whatley.

Surgery only.—S. Child, M. W. Cohen, *T. T. Kelly, *R. L. Jiménez, *M. J. Rees.

Midwifery only.—H. Bentley, R. T. Collins, *C. H. Gask, J. W. Gromitt, *G. S. C. Hayes, W. W. C. Jones, G. Moir, A. C. Nash, H. T. Palmer, C. J. Pinching, S. L. Prall, T. Morland Smith, V. M. Wallis, H. P. Wiltshire.

*Denotes completion of examination.

Births.

BURRELL.—On February 17th, at Arlaric, Kew, the wife of Lionel Cottingham Burrell, M.A., M.B., B.C. Cantab., of a daughter.

RANDALL.—On February 6th, at Queen's Road, Wimbledon, the wife of Philip N. Randall, M.B., Lond., Royal Navy, of a daughter.

STEWART.—On February 16th, at Walton House, Lordship Lane, S.E., the wife of H. M. Stewart, M.A., M.D., Cantab., of a son.

TURNER.—On February 10th, at "Balgownie," Bridge Road, Battersea, the wife of H. Stanley Turner, of a son.

WILLS.—On February 6th, at 59, Apsley Road, Clifton, Bristol, the wife of W. Kenneth Wills, M.B., of a son.

Death.

BLATHERWICK.—On February 6th, at his residence, Queen's Mead Road, Bromley, Kent, Deputy-Surgeon-General Thomas Blatherwick, in his 79th year.

Ed.—D. G. G.

Contents.

	PAGE
Gonorrhœal Arthritis: Clinical Lecture by Mr. Jacobson (continued)	105–110
Medical Heresies (continued)	110–112
Types	113
Papers by Guy's Men	113
An Open Letter	114
Passim	115–118
Recent Additions to the Dental Museum	118
Chapel News	118
Guy's Arms	118
Appointments	119
Guy's Hospital Out-Patients' Tea Fund, December 31st, 1901	119
Medicine for the Million	120
Reviews	120–121
Sport: Rugby Football—Guy's v. London; Guy's v. Harlequins; Guy's v. King's; Guy's 2nd XI. v. Merchant Taylors School. Association Football—Guy's v. London; Guy's 2nd XI. v. St. Thomas's 2nd XI.; Guy's 2nd v. Bart's 2nd	121–124

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold will be One Shilling and Sixpence.

Calendar of Coming Events.

March, 1902.

Sat. 15.—1 p.m., Clinical lecture by Dr. Taylor.
Messrs. Lucas and Lane's take-in; Drs., H. S. Brown and A. R. Wilson; Cl., A. R. Thompson.
G.H.R.F.C. I., London Irish, away.
II., Croydon II., away.
G.H.A.F.C., I., Tunbridge Wells, away.
II., Ewell 2nd XI., away.

Mon. 17.—1.15 p.m., Clinical lecture.
Last day for sending in Fees and Certificates for Camb. D.P.H.

Tues. 18.—Application to Med. Sch. Office for Schedules for the Final Conjoint Exam. to be made not later than this date.

Wed. 19.—Exams. for Junior and Senior Prizes for General Proficiency for the Michael Harris Prize and for the Wooldridge Memorial Prize begins.
1.30 p.m., Clinical lecture.

Thur. 20.—Messrs. Golding-Bird and Dunn's take-in; Drs., L. S. Glanville and E. N. Jupp; Cl., J. Atkins.
Exam. for Golding-Bird Gold Medal and Scholarship begins.
Dental Surgery Exam. for Second Year's Prize—2 to 4 p.m.
Dental Surgery Exam. for First and Second Year's Prizes—2 to 5 p.m.

Sat. 22.—1 p.m., Clinical lecture.
G.H.R.F.C., I., Richmond, away.
II., Hammersmith, away.
III., U.C.S. Old Boys "A," away.

Tues. 25.—Dental Anatomy Exam. for First and Second Years' Prizes—2 to 5 p.m.

Wed. 26.—School Examination in Elementary Anatomy.
Dental Physiology Exam. for First and Second Year's Prizes—10 a.m. to 12 noon.
Dental Anatomy Exam. for First and Second Years' Prizes—2 to 5 p.m.

Thur. 27.—Messrs. Jacobson and Fripp's take-in; Drs. P. W. Hamond and F. C. Robinson; Cl., S. Hodgson.
Winter Session ends.
G.H.C.C., Annual General Meeting.

Fri. 28.—Good Friday. Medical School Office closed.

Guy's Hospital Gazette,

MARCH 15, 1902.

Gonorrhœal Arthritis.

CLINICAL LECTURE BY Mr. JACOBSON.

(Continued.)

Next as to the chief points in the diagnosis, and the chief diseases which have to be remembered.

The chief points in the diagnosis.—1. *The age.*—Gonorrhœal arthritis is for obvious reasons chiefly met with from about twenty to about forty. You will remember occasional exceptions. As we have seen, it may be met with in infants with gonorrhœal conjunctivitis and again in children, not always as a result of assault, but as a result of contact with soiled sponges, or the dirty linen of adults. Finally, of course, you may sometimes meet with gonorrhœa, and therefore the complications of gonorrhœa in patients, especially males, who are a long way over forty. But with these occasional exceptions the above rule as to age holds good.

2. *Sex.*—Gonorrhœal arthritis is more commonly met with in males, but this prevalence has been much exaggerated. It used to be explained, when the pyæmic theory to which I have alluded was in vogue, by the greater length and the more complicated nature of the male urethra. The numerous glandular recesses, especially when the posterior and deeper parts of

the male urethra are reached by the gonococci, and the different habits of men as to drink, &c., is probably a better explanation. But bear in mind that gonorrhœal arthritis is by no means uncommon in women, and that the so called phlegmonous arthritic, often periarthritic variety "is quite as often found in the female as in the male, perhaps more often" (Davies-Colley), and it is not only in the young and single women who have been led astray that you will meet with gonorrhœal arthritis. The case which forms the subject-matter of the lecture shows how it may occur in married women. Two years ago I had another case of this kind. Having occasion to do an operation in a town in the Northern Midlands, I was asked by the medical man to see a case of puzzling and very troublesome joint-trouble in the Cottage Hospital. The woman was married, the mother of several children, æt. 38. One elbow-joint was a typical instance of the "phlegmonous" arthritis of gonorrhœa. Incisions had been made in the belief that the case was one of septic cellulitis and that pus was present. My diagnosis was received with courteous but firm disbelief on the part of the medical man. He knew the woman and her husband well, she was the wife of his coachman, etc. My only reply was that while I did not pretend to explain how the mischief was brought about, the case was one of the above variety of gonorrhœal arthritis, and nothing else. If he liked to take the patient into the operating theatre—I dare say you have known a cottage hospital, the beds are sometimes near each other, and an examination of the kind needed was certain to set up a most undesirable amount of curiosity—I thought I could convince him. No sooner said than done. I passed a vaginal speculum, and there issuing from the os uteri was a yellow, muco-purulent discharge. I have little doubt that the patient was the subject of gonorrhœal cervical endometritis. The case, after previous weeks of obstinate resistance to careful treatment, quickly improved, and got steadily well by attention to the three rules which should govern your treatment of these cases, and which will be given later in fuller detail, viz.:—Cure the discharge, give absolute fixity and supporting compression to the joint, and, when needful, improve the vitality of the patient.

3. *Onset of the arthritis.*—This may occasionally be met with quite early in the disease; but this is exceptional, as a rule the onset is much later, several weeks, even two or three months elapsing before the arthritis appears. I have already alluded to the frequency with which it accompanies the gleety stage of gonorrhœa. The fact that the appearance of the arthritis is usually late may be partly explained by the gonococci at this later stage having had time to reach the posterior part of the urethra, the annexa of the urethra and the gland recesses being in any of these cases less readily reached by injection, and unlikely to be flushed out by the urine. Dr. Lorimer, of Buxton, in a paper to which I shall refer again, considers that the interval from the onset of the gonorrhœa to the occurrence of the arthritis, is longer in women than in men. From an examination of two hundred and fifty cases under his care he found that in women the interval averaged three months, in men six weeks.

4. *The joints attacked.*—We have seen that those commonly attacked are the knee, the ankle, the elbow, the wrist and shoulder, we have also seen that the joints attacked vary somewhat with the two more common forms of gonorrhœal arthritis, the form with effusion attacking the knee, the ankle and the shoulder, the so called phlegmonous articular and periarticular form the wrist and elbow. But while the above are safe general rules, remember these points, (*a*) any joint may be attacked in some cases; (*b*) the joints attacked may be, as pointed out by Dr. A. E. Garrod, out of the way ones. Inflammation not otherwise to be explained, of such joints as the temporo-mandibular, sacro-iliac, etc., should at once arouse your suspicions. I am so convinced, from experience, of the value of these remarks of Dr. A. E. Garrod as to the importance of remembering out of the way joints in the diagnosis of gonorrhœal arthritis, that I will submit another suggestion to you which you will find worthy of your attention in after-practice, and that is, whenever you find an ankylosed joint and wasted muscles of unexplained origin, think of a past gonorrhœal

arthritis as very possible. When a case comes to us late, even too late for treatment, it is very satisfactory to have cleared up the diagnosis. (*c*) The arthritis is usually mono-articular. When more than one joint is attacked it is usually symmetrical joints such as the two knees, ankles, or wrists, or, a rarer condition, if poly-articular and migratory, this is only so in acute cases, and temporary. That is to say, if several joints appear to be acutely attacked, the mischief soon settles in one, the rest clearing up.

5. *The amount of pyrexia, inflammation, and pain present in gonorrhœal arthritis.*—Of these there are three types. (*a*) The acute; this as I have said, is rare, and when present brief in duration. (*b* and *c*) Subacute and chronic. These, especially the last, are far more common. As a rule the reactional phenomena are much less intense than in rheumatic fever, the pain is also less, though it may be very crippling and wearing when it attacks the ankles, and perhaps as well the plantar fasciæ in a patient who has to try and keep about on his feet. As we have seen, the swelling, redness, and œdema vary with the variety of the arthritis, the first being most marked when an hydrarthrosis is present, redness and œdema when the mischief is mainly capsular and peri-capsular.

6. *The discharge.*—I put this late, because as I told you earlier in the lecture, while always to be remembered, it is a diagnostic point difficult to attain in many cases, and especially in private practice. In many cases you will have to forbear from making enquiries, and to trust to other evidence. Remember what I told you earlier in this lecture about the difficulties in determining the existence of a discharge in these cases of gonorrhœal arthritis, especially in women, the difference in micturition in the two sexes, the difficulties which may arise from modesty and ignorance in one sex, and from indifference in both. Remember the frequent occurrence of this arthritis in the gleety, and therefore the quiet and painless stage of the gonorrhœa. On no account forget the long vitality and latency of gonococci in certain localities along the genito-urinary tracts of both sexes, though all external evidence points to a cure of the gonorrhœa, and how easily and unexpectedly these gonococci after long quiescence may be excited into activity. Neisser found gonococci present in eighty cases of chronic gonorrhœa; in eighteen they had lasted over one year, and in ten cases over two. Neisser is a most reliable observer, and thought he had excluded the fallacy of re-infection, which, has of course, always to be remembered. As instances of how easily the gonococci may be excited into activity and so give rise to complications such as arthritis, remember the influence of alcohol, excess in coitus, especially post-marital, when the husband is still tainted, and less common ones, but still to be remembered, viz., menstruation, pregnancy, and curetting the interior of the uterus. The deeper parts of the genito-urinary tracts, the mucous membrane of the uterus, are to be looked upon as possible culture-tubes, just as much as are the appendix and the tympanum. Before leaving the subject of discharge in gonorrhœal arthritis, I will remind you that there are other urethral discharges beside those due to gonorrhœa. Nowadays we are perhaps too much inclined to look upon every urethral discharge as gonorrhœa, and to neglect other possible causes. The usual pyococci often present in the urethra, and hence we have a urethritis due to the introduction of a catheter, even a sterile one, if slight bleeding be caused, or if the instrument be tied in. Prolonged venereal excitement, especially excess in alcohol, and when the woman has a leucorrhœa, and is near a menstrual period, is another rare, but undoubted cause. The irritation of uric acid crystals may, more rarely, also bring about a urethritis. But with regard to these discharges which contain no gonococci, you will notice that the incubation is shorter and much less definite, that the discharge is sometimes muco-purulent, and, if purulent, rarely as profuse and greenish-yellow as in gonorrhœa. There is less redness and swelling of the meatus. There is much less pain and sweating during micturition, and painful erections are much less marked. You will also notice that with none of these non-gonorrhœal urethritis do joint complications occur, except in these very few cases, all quite different from the gonorrhœal arthritis which

we have been discussing to-day. In one group pyæmia may be present, and affect one or more joints. If a patient, especially one of poor vitality, have pyococci in his urethra, and these be lit up into activity by the use of a catheter, there is nothing to prevent pyæmia ensuing and attacking one or more joints. In another group there is no pyæmia. Gout, we know, attacks joints, though the attacks nowadays are less frequently of the acute, classical, typical sthenic kind that characterised the disease in days gone by. We have seen that occasionally a urethritis, due to the irritation of uric acid crystals may occur in gout. I have only time for one more of these rare associations of arthritis with a non-gonorrhœal urethritis, I refer to the connection of a long continued leucorrhœa, especially if coupled with anæmia, as a causal factor in the joint changes of osteo-arthritis.

The chief diseases to be diagnosed from gonorrhœal arthritis.—After all I have already said about the chief points in the diagnosis, I need only refer to this heading briefly. The diseases are chiefly three.

1. *Acute rheumatism.*—The chief aids here are: (*a*) The pyrexia, pain, etc., are less in gonorrhœal arthritis; while acute symptoms may be present they are uncommon, a subacute and chronic course is far more common, and, as a rule, the more gleety the discharge, the less acute the pyrexia, etc. (*b*) The number of joints attacked. While in the less common cases, where the arthritis is acute, several joints are attacked, this condition is a temporary one, the acute stage soon passes into a subacute one, and settles down on one or two, usually symmetrical ones. The more chronic and gleety the discharge, the more likely is the joint-trouble to become mono-articular. Never, under any conditions, does the arthritis become general, in anything approaching to the degree met with in acute rheumatism. (*c*) Drugs which give well-known relief in acute rheumatism, *e.g.* salicylates, are quite useless in gonorrhœal arthritis, a single exception being those cases in which gonorrhœal arthritis occurs in a patient who has had one or more attacks of acute rheumatism, and here also, if the arthritis be of the chronic type, the above drugs will have no effect whatever. (*d* and *e*) In gonorrhœal arthritis, whatever perspiration be present, it has not the peculiar acid odour of acute rheumatism, and there is no characteristic modification of the urine. (*f*) Cardiac complications are exceptional in gonorrhœal arthritis. Dr. Lorimer, of Buxton, has published the following facts as to this most important complication (*Quarterly Medical Journal*, November, 1900, p. 1). "Cardiac complications were seldom present. In the two hundred and fifty cases, there were ten in all, or 4 per cent. of the total number of cases. Four belonged to the acute type (which numbered twenty-five) being 16 per cent. of them, five belonged to the subacute form (which numbered one hundred and seventy-eight) being 2·6 per cent. of these cases, and one belonged to the chronic form (which numbered thirty) or about 3 per cent. of these cases. Of the cases of valvular disease in the last two divisions (the subacute and chronic types) four existed previous to the gonorrhœal arthritis, and probably originated in a previous attack of rheumatism. Of the remaining six cases, which occurred during the course of gonorrhœal rheumatism, one case was attended with all the symptoms of infective endocarditis, and terminated fatally." (*g*) Discharge. I put this last, though it is the most valuable point in the diagnosis, if it can be detected, as I wish you to remember, on the one hand, the fallacies and difficulties which may surround this point, and with which I have already dealt, and on the other, the other important points in the history and diagnosis which will help you, if the discharge appears to fail you.

2. *Cellulitis.*—We have seen how the so-called phlegmonous capsular and pericapsular variety of gonorrhœal arthritis is liable to be confused with cellulitis and useless incisions made. The following are the chief aids in the diagnosis. (i.) The above variety of gonorrhœal arthritis begins about a joint, usually elbow or wrist, however far it may extend from it. (ii.) There is no wound. (iii.) The severity of the illness, the evidence of septic trouble, the pyrexia, the dry tongue, etc., are much less marked. (iv.) Discharge if present (*vide supra*). (v.) Treatment. The results of this, if judicious,

especially well applied fixity and supporting pressure, are decisive in clearing up the diagnosis.

3. *Tuberculosis.*—The case which forms the text of this lecture shows that gonorrhœal may be mistaken for tubercular arthritis. I have already, early in this lecture, given the chief distinguishing points.

4. *Gout.*—As I have seen, three days ago, a patient with gonorrhœal arthritis of one wrist who had been most carefully treated, first for rheumatic and then gouty joint-trouble, I may mention this possibility of mistake. The patients are usually younger, the habits which conduce to, and history of gout are absent, the joints attacked are usually different; while a urethral discharge may be present in gout, it is rare, and the attendant and pre-existent circumstances are widely different. Lastly, the treatment will always be decisive, that for gout will be useless, while the correct treatment of gonorrhœal arthritis will meet with success according to the date at which the patient comes under your care.

Prognosis.—Here you are liable to be asked one question, and that is, how long the arthritis is likely to last. Be cautious in giving your answer until you have learnt all you can about your patient. Six weeks to six months has been given as the average duration of gonorrhœal arthritis. I consider this too long, and based on the results of treatment which hitherto has been too often incorrect, and therefore unsatisfactory. The chief points on which your answer will depend are: How far the patient will be amenable to proper treatment, and especially as to getting his discharge cured. How far he will shun any risks of fresh infection lighting up an old discharge not cured. Any fresh lighting up of the discharge is extremely likely to be followed by renewed joint trouble, and such recurrent joint troubles are likely to be worse as to obstinacy than the first. The vitality of the patient, and to a certain extent the joint attacked, are of importance. A patient sometime out of work, depressed in mind and bodily strength, compelled to get about as an out-patient with his ankles and plantar fasciæ attacked, is a difficult one to cure. We have very little evidence before us how far any rheumatic taint in the patient affects the question of cure. A very important point in the prognosis is, how long the arthritis has lasted before the patient came to you. The greater the length of the interval, the more likely is the vitality to be depressed and adhesions to have formed.

Treatment.—As the main principles on which a satisfactory result depends are very few, I shall be brief here. According to many of the books, the treatment of gonorrhœal arthritis is extremely unsatisfactory. You will *not* find it so, if you remember the following essential points. (1) Cure the discharge. (2) Enforce absolute fixity and supporting pressure to the joint. I find the best means of securing these ends is to put the joints up in the position most suitable to it, in plaster of Paris, as originally recommended by M.M. Duplay and Bruns, and in this country by the late Mr. Davies-Colley. In a few of the acuter cases it may be needful to spend a few days in treating pain, tenderness etc., by fomentations or ice. But in nearly every case I use plaster of Paris, taking care to protect the bony joints carefully, availing myself of an anæsthetic if needful, and in the acuter cases keeping the joint elevated for some hours before. Where much effusion is present, or where you can be certain of an aseptic needle and skin, it is always worth while to aspirate the joint before applying the plaster of Paris. In two or three days' time, when the pain has disappeared, either the plaster of Paris should be re-applied or an india-rubber bandage employed over a thin layer of cotton wool. Occasionally a case occurs in which the foot is chiefly affected, ankle and tarsal joints, plantar fasciæ, or all three, and it is most important for the patient to get about a little. Plaster of Paris may here entail a conspicuous slipper, and I find that a Martin's ankle bandage and a little cotton wool or a knee rest meet these cases best. When the plantar fasciæ is affected by gonorrhœa you know that it is liable to soften and bring about a rapid-formed flat foot. You should warn your patient of this, and where the plantar fascia is affected on both sides, rest off the feet for some days is imperative. About a week or ten days after the

commencement of the treatment by fixity and supporting-pressure the joint ought to be fit for your beginning careful passive movements, friction, douches, superheated steam by the Tallerman treatment and massage in order to prevent adhesion and ankylosis. These are likely in any case which comes into your hands late in the day; the liability to them will be much increased by prolonged fixation. (3) The general health should be improved in every possible way; the food should be simple and nutritious, some stimulant, such as a good claret, hock, or Australian Burgundy is usually indicated. (4) Drugs. The only ones likely to be of service are tonics such as strengthen. Steel in some such form as Blaud's pill, or syrup of the iodide of iron, and cod liver oil where the nutrition is much impaired. Aperients are not to be forgotten. Salicylates, potassium and iodide are useless and harmful in wasting valuable time. It is from the frequency with which such drugs as these are still given, and the want of fixity and supporting pressure, and the fact that the existence of a persistent discharge is not recognised, that it comes about that the treatment of gonorrhœal arthritis, not rheumatism, remember, is still so often unsatisfactory. (5) Active surgery. Beyond occasional aspiration of a joint the seat of much effusion before applying plaster of Paris, a step already mentioned, this is very rarely needed. Where much fluid persists, an uncommon contingency, it may be needful sometimes to drain the joint by a small incision, followed by firm supporting pressure; if the fluid drawn off is flakey, and washing out the joint seems advisable, I recommend you to use carefully boiled water and to get it all out. The use of chemicals such as mercury perchloride and carbolic acid solutions are liable, I think, to lead to a certain amount of aseptic inflammation, and thus to additional adhesions.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Medical Heresies

A paper read before the Physical Society on January 29th, 1902, by Mr. Owen Richards.

(Continued.)

When we come to examine this theory we are met by a number of difficulties.

In the first place, Mrs. Eddy's discovery that life is simply a succession of sensations, and matter the hypothesis we instinctively frame to account for their occurrence, is no new thing. This truth was set forth with admirable clearness by Bishop Berkeley at the beginning of the eighteenth century, in his treatise on the Principles of Human Knowledge, and has been a commonplace of metaphysics ever since. To the founder of the Massachusetts College of Metaphysics it is apparently a new idea; and one of which she does not wholly grasp the consequences even now, for she proceeds in her book to continually deny that sense impressions have any truth or significance at all. For instance—

"Christian science sustains, with immortal proof, the impossibility of any material sense, and defines these so-called senses as mortal beliefs, whose testimony can neither be true of man nor his Maker."

"Corporeal sense defrauds, lies, cheats, and the same idea is repeated continually."

And of this she gives instances, of which I will quote one *in extenso*:—"The optical focus is another proof of the illusion of material sense. On the eye's retina, sky and tree-tops apparently join hands, clouds and ocean meet and mingle. The barometer, that little prophet of storm and sunshine, denying the testimony of the senses, points to fair weather in the midst of murky clouds and drenching rain. Experience is full of instances of similar illusions, which every thinker may recall for himself."

I have extracted this passage because it is such an excellent illustration of the fallacy at the root of her whole theory, and the way in which she envelops confusion of thought in poetical diction.

We have in the case of the barometer two distinct sets of sense impressions, one of the state of the weather, the other of the height of the barometer. Instead of simply observing that a high barometer sometimes coexists with very bad weather, she makes an assumption, based apparently on the word Fair which the maker has written on the dial, that whenever the needle points to that spot the weather must necessarily be fair at the time. If the other facts do not square with this conclusion so much the worse for the facts. They must be "delusions of mortal mind." That is to say that out of several sense impressions she arbitrarily selects one, bases an unwarrantable conclusion on it, and on the strength of this conclusion denies the very existence of another equally vivid sensation of a similar kind.

It is exactly the same with her theory of pain. She says this theory is proved by her cures. Certain religious

indications led her to the discovery of the theory, but she repeatedly states that the proof of it is in the cures.

Now all the evidence for these cures consists entirely of those sensations whose truth she so repeatedly and violently denies. The black and white print of her book, the voices of those that testify, and the feelings of relief which follow her treatment; all these are, when one comes to examine them, just as purely sensations as a toothache, and far less vivid and convincing. If we are to disbelieve in the toothache because it is a mere sensation, how are we to believe in the *existence* even of Mrs. Eddy or her book? For these are not even direct sensations, but complicated inferences based on sensations. And then she passes to the conclusion that if anyone is convinced that pain, disease, or wounds do not exist, they will cease to exist. Now in this there is a partial truth. It is no new idea that the mind exercises a good deal of influence on bodily sensations and processes. In the case of the slight ailments on which the leisured people who form Mrs. Eddy's following concentrate their attention, this effect is at its maximum. But we find by experience that this has limits. It is true that there are people who realize all Mrs. Eddy's dreams—people who feel themselves perpetually young, strong, beautiful and wise, under the most discouraging objective conditions. We have all of us been introduced to them by Dr. Savage at Bethlem Royal Hospital. It is possible that she is right when she claims that a continued study of her book would bring us all to this condition.

Another of her logical principles is the one which her followers summarize as "Part proved — all proved." This she calls Induction. But it would only be wasting your time to elaborate criticisms which occur at once to any man of ordinary common sense. What we are concerned with as medical practitioners is rather the practice of this sect than its theory. What do these four thousand qualified men do for their guineas?

Well, they have to admit that they do not always cure their patients. Mrs. Eddy has several lines of defence in cases of failure. In the first instance the method may fail because either patient or healer has not a firm grasp of the necessary truths. In cases where both are above suspicion it may fail because the false ideas of relations or friends react on the mortal mind of the patient. Even if these are people of sound views the belief of an unenlightened world may still step in and spoil the whole concern.

A difficult case is where a man has taken a dose of poison by mistake, believing it to be a harmless drug. In this case neither the patient nor his friends believe him to be poisoned, yet he dies. But Mrs. Eddy is not at a loss even here. It is true that nobody knows that this particular man has taken this particular poison, but there is a general erroneous belief in the world that doses of this kind are fatal, and this general belief acts on the man's mind and kills him. When the world thinks rightly on these matters such doses will cease to kill. In the interval it would seem wise for even the most enlightened to pay the tribute of an emetic to popular error.

Thus, whenever the scientist is cornered he casts the blame on an unregenerate world—which the doctors do more than anyone else to lead astray—and in matters practical he hedges.

Thus, marriage would seem a gross and cumbrous way of adding to the population. But Mrs. Eddy advises its retention "till the spiritual creation is discerned."

Pain is unreal, medical aid a delusion. Anyone who understands this book can cure it. Yet Mrs. Eddy, who wrote the book, recently took an aching tooth to the dentist, and allowed him to administer a delusive sense impression which he called nitrous oxide while he pulled it out.

Surgery, she says, can be performed mentally. She instances in support of this the resection of a rib which occurred in the Garden of Eden, as well as certain feats of her own, hardly less remarkable. "Yet," she tells her pupils, "until the advancing age admits the efficacy and supremacy of Mind, it is better to leave the adjustment of broken bones and dislocations to the fingers of a surgeon, while you confine yourself chiefly to mental reconstruction and the prevention of prolonged confinement."

Yet even here, in dealing with prolonged confinement, her practical directions are lacking in precision. Thus she says:—"Teacher and student should also be familiar with the obstetrics taught by this science. To attend properly the birth of the new child, or the Divine idea, you should so detach mortal thought from its material conceptions, that the birth will be easy and safe." I commend this method to the harassed extern. Space does not allow of the recital of Mrs. Eddy's own obstetric triumphs.

I recently attended a testimony meeting of this sect. The building was crowded with some three hundred people, almost all well dressed and well-to-do, the leisured monied class, in fact. As in other places of worship, about 80 per cent. were women.

We had a reading from the New Testament, one from Science and Health, some hymns, the Lord's Prayer, and then "testimony." The testimony was of the kind with which we are familiar at Salvation Army meetings, only instead of dealing with drunkenness and vice, it dealt with "liver complaint," "sore legs," and other diseases of obscure pathology. It was inoffensive, rather foolish, and not at all convincing.

Now, gentlemen, you must be wondering why I have inflicted on you this long disquisition on a futile creed like Christian Science. The reason is that it is to some extent a power in the land. These people number among their professing members a great many rich people, and some of some ability and social standing. They have a Senior Classic (of Cambridge) and a peer among their adherents. They have all the elements of popularity; they supply a soothing selfish religion, they give a sense of intellectual superiority, and they encourage people to think and talk about their own insides—a very taking

form of egotism. They do not discover idealism, or Christianity, or the power of the mind over the body, but they have distorted and combined all three and made the product a commercial success.

This being so, they are to some extent a danger. For they are quite willing—for the usual fees—to treat any case of illness. Harold Frederics, the novelist, died under their care without seeing a doctor. They treat cancer or pneumonia with equal confidence. Mrs. Eddy is a shrewd woman, who knows when to stop; her followers have all her enthusiasm without her sense. And I think you will agree with me that it is our duty to refuse to countenance or cover this mischievous nonsense, to combat it by all fair means; and to see, when occasion arises, that these practitioners have the opportunity of proselytizing a coroner's jury. I do not think that any responsible medical man ought to be complaisant enough to give a certificate of death in a case where the use of these methods has delayed rational treatment. It is not a case of persecuting religious enthusiasts. Men who take substantial fees for the rest of their lives on the strength of a three weeks' course of Massachusetts metaphysics may or may not be honest, but they cannot be said to deserve compassionate treatment.

As regards quack medicines proper, we are all familiar with their uses and methods. I have here a list of many of the common ones. They consist, as you may see presently, of very ordinary drugs. I am afraid their popularity is in some cases a reflection on our profession. The remarkable cures effected, for instance, by Clarke's blood mixture — the active ingredient of which is apparently Potassium iodide—suggest that a good many medical men must have failed to diagnose the real nature of these distressing "bad legs."

A good deal is due to advertisements; a good deal to the excellence of the drugs; a good deal to the healing power of nature. Their real defect they share with homœopathy—they have no pathology—their treatment is entirely by symptoms.

I will put up this list of their compositions and so bring this rather long paper to a close—

Patent Medicines.

Allen's Antifat.—A fluid preparation of Fucus Vesiculosus, the bladder sea weed.

Allen's World's Hair Restorer (in an 8-oz. bottle).—

Sulphur	75·6 gr.
Lead Acetate	87 gr.

Beecham's Pills.—Aloes, Ginger, Soap.

Clarke's Blood Mixture.—Potassium Iodide, gr. x. in a dose (Farquharson).

Dutch Drops.—Linseed Oil, 1 quart; Resin, 2 lbs.; Sulphur, 1 lb.; boil and add Oil of Turpentine, 1 pint; Liq. Ammonia, 50 minims.

Holloway's Pills.—

℞	Ext. Aloes	grm. 4.	
	Pulv. Rhei.	„ 1·7.	
	Peperidis	„ ·45.	
	Saffron } aa	„ ·2.	
	Mag. Sulph. }		

Misce. ft. pil 144.

Holloway's Ointment.—

White Wax	12½.
Yellow Wax	3.
Turpentine	3.
Resin	25.
Spermaceti	3.
Lard	50.
Olive Oil	62·5.

St. Jacob's Oil.—Oil of Turpentine, Camphor, Oil of Thyme.

Kitcheners Peristaltic Persuaders.—

Rhubarb	ʒ ii.
Ol. of Caraway	♏ x.
Syrupi	ʒ i.
	ft. 40 pills.

Lamplough's Pyretic Saline.—

Tartaric Acid	45·7 per cent.
Sodæ Bicarb.	52·4 „
Potass Chlor.	1·9 „

Mattei's Electricity.—Aqua Destillata.

Mattei's Cancer Cure.—Sugar, Starch, Calcium Sulphate, water, and some albuminous matter.

Mother Seigel's Syrup.—Aloes, Treacle, Borax, Capsicum, Liquorice.

Pond's Extract.—Hamamelis.

Powells Balsam.—Syr. Tolutani, ʒ ii.; Tinct. Camph. Co., ʒi.; Succus Glycyrrhizæ, ʒii.

Anna Ruppert's Skin Tonic.—At one time a solution of $HgCl_2$; now a solution of Boracic Acid.

Warner's Safe Cure. — Nitre, Glycerine, Treacle, Rectified Spirit, Oil of Wintergreen (a few drops), and and a vegetable extract resembling Liverwort.

Mrs. Winslow's Soothing Syrup.—Sugar, Alc. Tincture of Fennel, Anise, Caraway, with or without a varying amount of Morphine Sulphate.

Owbridge's Lung Tonic.—Balsam of Tolu, Oil of Aniseed. Oil of Cloves.

Daffy's Elixer resembles Tinct. Sennæ Co.

Hooper's Female Pills. — Ferrous Sulphate, Aloes, Canella.

Notice.

FINAL F.R.C.S. CLASSES.

The Class will be held at the following times:—

Clinical Demonstrations.—Mr. Dunn, Wednesdays and Fridays, at 9.30 a.m.

Operative Surgery. — Mr. Steward, Mondays and Wednesdays, at 3 p.m.

Surgical Pathology.—Mr. Targett, Tuesdays and Thursdays, at 10.30 a.m.

Surgical Anatomy.—Mr. Fagge, Tuesdays and Thursdays, at 9.30 a.m.

The Classes will commence on Tuesday, April 1st.

The fee to Guy's Students for the Course is £10 10s.

Guy's Hospital, March 10th, 1902.

Types.

VI.—The Courtier.

"T. P. or not T. P."—(Hamlet.)

"*I, myself, sometimes leaving the fear of heaven on the left hand, and hiding mine honour in my necessity, am fain to shuffle, to hedge and to lurch.*"—(Falstaff.)

Very hard by the summit of Breakback Beacons, in the uttermost recesses of the Forest of Brecon, our hero first appeared amid an excited chorus of "Indeet," "Whateffer," "Yakkerdoche Borbeem."

Long before that auburn aureole, which has ever excited his nurse's admiration [not at Guy's, I hope.—Ed.], had o'erspread his manly brow, he shewed a propensity to "dribble" down his tucker, and no little agility in evading the ensuing "scrimmage" that followed, characteristics he has entirely lost.

At school he imposed on his masters and evaded impositions: while at college he was noted as a good sportsman, and though always "forward" at Rugger he was put "back" by the selection committee (of Sassenachs).

He then arrived at Guy's and became a "type." (No insult intended.—Ed.) Here he was above all others a man well-fitted

"The applause of listening Committees to command,"

and his career was punctuated by appointments and crowned with success.

His pose was perfect, his presence imposing, his diplomacy delicate. A Talleyrand at the table, a Navarre in the field, he was *nevare* in the scrum.

Though frequently "offside," he never puts "on side." He was the father of his firm, the friend of his dressers, the pride of the "pros." and the patron of his patients.

As the golden glory of his ruddy locks has paled and fallen like leaves in Vallambrosa, his suave and decorous demeanour (with the aforesaid castle in W–l–s), has endeared him to mammas, midwives and medicoes, to waitresses and ward-maids.

Effusive in his manner, and recently in his knee, as an in-patient he commanded and later demanded sympathy in his terrible sufferings.

In his hours of relaxations his achievements are no less remarkable. He plays ping-pong by himself in the gymnasium!!

He is a devotee of dancing, but more effective in the Conservatory than the ball-room.

His voice favours the music-hall rather than the concert room, but his rendering of the "Land of my fathers" has been known to move compatriots to tears.

He suits his conversation to his company, and most company suits his conversation (?)

Obstreperous perhaps in masculine argument, when enveloped by frocks and frills (o.n. and t.d. at least) he becomes *facile*, and even flippant.

As a resident though often cornered he has never been confounded. He has found a new use for the strong room, an amanuensis for his bed letters (coram matrone), he has outmanœuvred the m–t–n, risen superior to the "Super" and cajoled Coles.

In this remarkable man, diagnostic skill and tactful diplomacy are so strangely intertwined that some competent observers have been unable to isolate either.

His friends are confident that he will enjoy a future as exciting as his "past."

JABBERWOK.

Papers by Guy's Men.

On Cleft Palate. By W. Arbuthnot Lane, M.S. Lond., F.R.C.S. Illustrated.—*The Lancet*, 15th and 22nd February.

A Case of Hydatid Disease of the Gall-bladder. By Lawrie Hugh McGavin, F.R.C.S. Eng.—*Ibid.* 22nd February.

On Uterine Displacements: Their Mechanism of Causation and Treatment. By T. G. Stevens, M.D. Lond., F.R.C.S. Eng., M.R.C.P. Lond.—*Treatment* for February,

Typhoid Fever in South Africa: its Cause and Prevention. By George Turner, M.B., D.P.H.—*British Medical Journal*, 15th February.

A Clinical Note on Latent Vaccinia. By J. W. Washbourn, C.M.G., M.D.—*Lancet*, March 8th.

The History of Fahrenheit's Thermometer. By Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S.—*Knowledge* for February, 1902.

An Open Letter.

[We have received the following from an old Guy's man. Although an obvious imitation of a series of letters that recently appeared in our pages, we think it is of sufficient intrinsic value to merit publication.—ED.]

To the Dean of a Provincial Medical School.

MY DEAR SIR,—Allow me to state, before any other remark, that I entertain the profoundest admiration for you in your capacity of a dean, whatever my opinion of you as a man may be. No one who has had the opportunity, as I have, of checking his career by yours can fail to be struck with the capabilities which you possess of coming out on top in any mental tussle with one of your flock. When you decided on medicine as a profession you undoubtedly missed your vocation. What a field lay before you in the profession of Buzfuz.

I really want to be angry with you, but I find I cannot, for even while I am shaking with rage and disappointment I find a sense of real admiration displacing the anger, and in the end I can only wonder at your Cinquevallian powers. Of course you won't remember the day that I entered. It is even doubtful whether you will even remember my name. Needless to say, that first day has lived in my memory ever since. I was shown into your sanctum and smiled into a chair. No need then to ask my name: that would have been very clumsy wouldn't it? You congratulated me on my choice of school and at the same time implied that a measure of congratulation was due to the school itself. I had only recently left school, and what schoolboy could withstand flattery of that nature? I had originally intended merely to make myself acquainted with the conditions which held at your school with the view of making a comparison between it and others. When I left you I was committed to your school, past recall, and the next day saw the payment of my composition fee. Of course it was weak on my part, but it was none the less smart on yours. I was a stranger, and you took me in.

Composition fee—yes, I should like to talk to you about that composition fee of yours. The word composition is well chosen if only for its multiplicity of meanings. One is, to quote a lexicographer, the "settlement of a debt by an accepted reduction," and I think that is the meaning that most would put on the word in this connection. After finding that the composition fee franked the student only as regards verba, while an additional fee was always demanded for facta, I have come to the conclusion that you must have meant the alternative meaning "putting words together in sentences." That would not be a bad subject for a prize essay, would it, "the value of lectures—to the lecturer." So I found out that my cheque only entitled me to listen to lectures, formal and informal. But I must not say only, for I was also allowed later on to assist in the management of the Infirmary to which your school was attached and which by the help of my colleagues and myself was thus saved the necessity of a large salaried staff. All practical work that entailed the smallest expenditure of money or material required an additional sum in guineas. Does it not strike you as being fairer that at the outset I should have been told that my composition-fee was a polite fiction and that I must be prepared for a not inconsiderable further expenditure? I suppose if you said too much you would frighten men to other places. I can well remember the tone with which you received my mild remonstrance when I was called on for the first further fee. I left our original interview with the feeling that I had become your personal friend and the friend of all the Staff. But after the next visit, when we discussed the dissecting-room fee, I realized that I was only a negligible quantity in the economy of the school. I hardly dared face the clerks in the office as I went through to the open.

My next experience of your versatility was when I interviewed you on a delicate matter of schedules. I found myself a perfect stranger and faced by an immobile and eminently judicial countenance. Reference to many tomes of a portentious nature served still further to overawe me, and it was with a feeling of almost relief that I left you, although I was aware that my hopes for the Second were dashed to the ground. I had many excuses ready for the insufficient number of lectures with which I was credited, one of which was based on the futility of attempting to learn an exact subject from a more or less inexact dissertation. But they were still-born, and I spoke not a word in my own defence. Now, looking backwards, I wish I had reeled out my pleas, if only for the delight of listening to your sophistry. Much of it has been vouchsafed me since, and it has been really delightful. I know no other man who can approach you in the art of saying much, meaning little, and promising less. In these days of hard facts and keen competition, it is refreshing, though intensely irritating at first, to meet with a philosopher of the sixteenth century. Once, in a spirit of recklessness, I consulted you on a matter concerning my future. Frigid politeness rapidly thawed into genial attention, and I began to think that perhaps you had, after all, cherished a secret interest in my career. All my hopes, my aspirations, were listened to attentively and gravely, with now and then a non-committing comment. But when I had left you, and had mentally rehearsed that interview, I found that I had gained—nothing. Words I had heard many; but advice, I had received none. It was never my good fortune to become qualified to practice the arts that your school had taught me, hence I am unable to remind you, from personal experience, of your methods in dealing with this class of student.

Well, as I said at the beginning, I still preserve a sneaking admiration for you, and can in all sincerity wish you many long years of success in your own inimitable line. But you won't believe me, I fear.—Faithfully yours,

Passim.

The question as to what form the South African Memorial shall take seems almost as difficult a matter to decide as the war itself. At a meeting of the Gazette Committee this week it was proposed to call a general meeting of subscribers, and those interested, during May, and to lay a few definite schemes before them. Meanwhile a circular letter is to be sent to all old Guy's men and others connected with the hospital drawing attention to the scheme. The one point on which nearly everybody seems unanimous is that the memorial should not be utilitarian. There is, perhaps, a balance of favour on the side that it should be erected in a prominent place out of doors, but as to what form such an erection shall take cannot be exactly said till the amount of money likely to be subscribed is known. The proposed site is the grass plot between Guy's and Hunt's Houses. Of course, any out-door memorial to be in the least worthy of its object would require a much greater sum than the one which is at present to hand.

Another scheme which meets with a large amount of approval is to have a bronze relief placed in the "Will's Library," which is shortly to be taken in hand. This is to occupy the ground floor of the temporary Nurses' Home, and it is hoped that it may be finished before the end of the year. This would be a prominent position as it is on the chief way into the proposed new museum, and such a memorial would harmonize with the general surroundings, as the library is to be panelled in oak.

It is with regret that we hear of the financial crisis in the affairs of the Clubs' Union. The officials have for many years attempted to restrict the expenditure, but the falling off in the receipts has necessitated a 20 per cent. reduction all round in the grants. As the allowances have been already cut down to a minimum, the secretaries of the various constituent institutions are beginning to feel the extra screw. The rates have steadily increased, while the natural process of wear and tear causes fresh demands, to meet which there is no deposit account, in fact, the Union has always had to live up to its income instead of being able to annually set aside a portion of the compounded subscriptions. As matters stand, either the revenue must be increased or the efficiency of the various Clubs impaired; are there no budding financiers who can by assistance or suggestions relieve the cares of the hard-working Honorary Treasurer, Mr. Steward, and his colleagues?

The Students' Club has decided, through its Committee, to instal the electric light into its quarters in the College. "That is easy," as the Leg of Mutton said in *Alice through the Looking Glass*. The only difficulty that arises is in the payment of the electricians' bill. A sum of, roughly, £180 is required for this purpose, and with a cheerful deficit ever in view the Financial Committee has been forced to seek outside aid. With a wave of the magician's wand, there enters the Gazette, disguised as a fairy godmother, and the poor Cinderella in Maze Pond sees visions of glittering magnificence through our friendly aid. The money will be lent by the Gazette Committee, subject to the usual formalities of security for capital and interest, and the Dining Hall, the Reading Room and eke the Smoking Room will emerge from their melancholy gloom. The Hospital plant will supply the energy at the most reasonable rate of 3d. per unit, and by charging a somewhat higher rate to subtenants the Students' Club hopes to come out on the right side of the balance sheet. We hope so too.

At the Physical Society last Wednesday, Mr. Davidson read a most excellent paper, based on a case of acute Bright's disease in which suppurative peritonitis and empyema occurred. It seems a pity, living as we do in an age of advertisement, when the magic name of Dewar is nightly flashed across the Thames by ever-changing lights, that a few more notices of these meetings could not be posted up in prominent places. Now that the Society meets on alternate Wednesdays and Saturdays, men (and even

secretaries) find considerable difficulty in remembering the dates. When a man has taken the trouble to write a paper, it is only common courtesy to insure that he shall have as good an audience as possible.

London, by effecting a drawn game with us in the Rugby Cup-ties, gave a considerable shock to our belief in our own powers and perhaps at the same time administered a very healthy tonic both to the team and the interest in the competition. The weather was much more suited to our interests in the re-played tie, and we won, as stated in the bare note received just in time for our last issue. Our team made a better display and thoroughly deserved their victory. Harrison was incapacitated and Pye-Smith took his place, and filled it very creditably. The forwards made a considerable improvement in their display in the previous match, and gave our outsides a much better chance of scoring. A very regrettable incident was the injury to Alcock, who sustained a compound dislocation of his thumb. He has played such a number of great games since he has been up, and has been such a prolific scorer, that his loss will be badly felt. It was fortunate, however, that the accident did not occur earlier in the game. We are very pleased to state that he is recovering in a satisfactory manner.

The past week has been a particularly noteworthy one in the annals of our football season for we have qualified for no less than three final cup-ties in the Inter-Hospital contests. On Monday our second eleven defeated St. Bart.'s in the semi-final of the Junior Association Cup competition, and ran up the respectable score of eight goals to nil. Although not at full strength they had a strong side and played a good game, which, if repeated, should end in the acquisition of the Cup.

On Tuesday the Rugby team amassed a considerable number of points against King's College Hospital at Richmond. Although we had not the services of Harrison, Alcock and Glendinning we effected a great victory by eight goals (one dropped) and five tries to our opponents' nil. This is the largest score we have made for some time, and improves the look of our score sheet for this season, large as it is already. Such a game requires little in the way of comment.

The match at Winchmore Hill against London, on Wednesday, in the Association ties ended in a good win for us by three goals to one. Wragg, after being on the shelf for some weeks, was again able to take his place on the right wing. During the first half of the game our men did not show up to advantage, London having at least as much of the game as we did, but during the latter part of the game we asserted our superiority and gained a decided victory. The play of the forwards was particularly good, the wings put in many excellent centres, and the reproach of bad shooting was removed by our inside men, who put in some good work, particularly Norton, who scored two of our goals. Our defence was quite up to its usual standard, Edey perhaps doing as well as anyone. Collins made a number of good saves and cleared the ball well. We meet St. Mary's in the final next Monday week at Queen's Club, and hope to do ourselves more justice than in the match against them on the same ground last year.

It was an unfortunate occurrence for the name of hospital association football last Friday week, when our semi-final tie with London Hospital failed to take place, owing to what the *Sportsman* calls a misunderstanding with regard to the referee. The match was arranged at rather short notice, and it would be easy to suggest an improved and more definite arrangement for the future, but our object here is to lay the charge of gross mismanagement at the door of the London Hospital Association Football Club. Many views with regard to their conduct have been expressed, and we can only say, that, seeing they wired on Thursday to say that they were playing, that on Friday morning they sent representatives to try and scratch the match, and that on Friday afternoon they failed to produce the referee whom they had promised, we cannot blame anyone who takes an uncharitable view of their conduct, when we remember that they had only ten men on the field, and

several of them admittedly not "soccer" players. Probably one individual is more to blame for the muddle than a whole club; and, in the main, no doubt it was a muddle, but an individual arranging cup ties is, for the time being, in a responsible position and must be correspondingly careful. With the deciding of the match on Wednesday last, the incident closes, but it is a serious thing if such a question as the claiming of a match without playing it is to be even only thought of in hospital cup ties.

The balance-sheet relating to the Out-Patients' tea is most satisfactory—it would indeed be well for the hospital if every fund was in as flourishing a condition. In addition to helping the Samaritan Fund and the Haven, as in former years, it has been decided to maintain a Cot in the hospital for the coming year. We understand that a brass plate is being prepared for the Cot. We hope that once having been fixed up every effort will be made to retain it in its place for many years to come.

At that imposing first meeting held in the little dissecting room theatre the senior demonstrator would sometimes moralize on the possible futures of the men sitting before him for the first time. Whilst some would achieve greatness, the majority would have to be content with moderate success, and a few were doomed to utter failure. In a recently published book of selected essays by the late Sir James Paget, there is an address on "What Becomes of Medical Students." The writer taking as his text the story of Mr. Abernethy looking round at the crowd of students at one of his lectures and exclaiming "God help you all! What will become of you?" attempts to answer this question, and analyses the careers of a thousand students at St. Bartholomew's Hospital. Of these, twenty-three achieved distinguished success, six hundred moderate success, forty-one died during pupilage, the majority from phthisis, and fifty-six failed entirely. Some because they could not pass their exams. through sheer want of intellect, others from intemperance and dissipation. Amongst those who left the profession, one became a forger, three turned actors, the Church claimed seven, and one, the notorious Palmer, distinguished himself by committing murder.

The gentle art of puffing has from time to time claimed many distinguished followers—was not the great Lord Byron said to write lottery puffs?—and recently an H.-S. of a hospital not a thousand miles from Guy's, has been pleased to publicly announce the fact, "I find —— cigarettes most excellent. Many of the resident staff here have tried them and all say they are the finest in the world." If our Residents were to follow this lead the Charities' Fund would soon cease to be necessary.

We have received a reprint of the paper by Dr. Elliot and Dr. Washbourn on "Typhoid Fever in South Africa." The study of some 262 cases, all of which were in the acute stage when in the hospital, tends to show that the type of fever met with out there does not differ in any essential respects from that occurring in England and America. Out of 211 of the authors' cases, 186 had not been inoculated, and these had a mortality of 10·7 per cent., whilst a mortality of 16 per cent. occurred amongst the 25 who had been inoculated. On the whole the authors do not think inoculation had any marked influence, either in preventing or in modifying the disease.

We take the following cutting from the *Daily Mail*:—

LADY WARWICK'S ILLNESS.

As the result of the hunting accident on Monday while out with the Warwickshire Hounds, the Countess of Warwick is suffering from concussion of the brain.

Mr. Alfred Fripp, the eminent surgeon, has been called into consultation with Dr. Wellesley Garrett, *but no serious results are anticipated.*

Her ladyship is making satisfactory progress.

So nicely expressed! Isn't it?—The italics are ours.

The notice regarding the Final Fellowship classes sent us for publication in our last issue should have been supplemented by a note to the effect that the fee for Guy's men is £10 10s. for the course.

MR. STEWARD is now taking Mr. Symond's position at Surgical Out-patients' on Thursday afternoons, but after April 1st he will change days with Mr. Fripp. Mr. Steward will then take Saturdays and Mr. Fripp Thursday afternoons. We also hear that Mr. Laidlaw Purves is relinquishing his post as Surgeon to the Aural department.

Recent Additions to the Dental Museum.

The teeth of a male Raia Clavata (Thornback Ray).

The jaws and teeth of the galens canis. Model taken from the mouth of a female, æt. 30, which shows a papillomatous growth in the anterior portion of the palate.—Mr. G. W. Badcock.

Four models illustrating the effects of congenital syphilis on the permanent teeth.—Mr. E. B. Dowsett.

Model of the upper jaw of a female, æt. 55, taken after the removal of the left maxillæ for carcinoma.—Mr. P. Scott.

Models from the mouth of a patient, æt. 17, showing marked deficiency in the number of teeth. In the upper jaw the only permanent teeth present are four molars and the two central incisors. In the mandible there is one molar and a canine on each side and a premolar on left side.—Mr. A. H. Clogg.

Irregularity of teeth in the front of the mandible brought about by the retention of the temporary canines. —Mr. G. W. Badcock.

Models and skiagrams of the maxillæ of a boy, æt. 11, in which three supernumerary teeth are seen in the incisor region, partially erupted. The right central incisor is considerably displaced.—Mr. H. C. Visick.

A lower right second molar with absorption of the posterior root, due to the impaction of the wisdom tooth. —Mr. W. A. Maggs.

A simple contrivance for applying continuous pressure to the gum and alveolus in cases of obstinate hæmorrhage. —Mr. M. F. Hopson.

Right upper lateral incisor germinated with a supernumerary tooth.—Mr. M. F. Hopson.

Models of a case of irregularity successfully treated by means of alveolotomy.—Mr. W. H. Dolamore.

A case of successful replantation with a second model taken nine months later.—Mr. W. H. Dolamore.

Models of two cases of "missed superior protrusion." —Mr. T. Constant.

Models of three cases of superior protrusion in children under 5. In one case a well-marked open bite is associated with the condition.—Mr. G. G. Campion.

Model of maxillæ showing a molariform supernumerary tooth displacing a left upper central incisor.—Mr. Gaffney.

A molariform second premolar which was removed from the left side of the lower jaw.

A three-rooted second upper premolar and a four-rooted second lower molar.—Mr. W. H. Morris.

A plaster model of the maxillæ of a child, æt. 4½, which shows a right supplemental temporary lateral incisor.—Mr. W. A. Maggs.

Model showing two supplemental laterals situated immediately posterior to the upper central incisors. —Mr. Payne.

Model of maxillæ with the left permanent canine erupted posterior to the first premolar. The temporary canine is retained.—Mr. G. Naish,

Sixty-five lantern slides illustrating the nature and treatment of various irregularities of the teeth.—Mr. J. H. Badcock.

Models of a case in which germination had occurred between a right upper lateral incisor and a supernumerary tooth. The corrected position of the teeth after treatment is also shown.—Mr. A. E. Baker.

The left half of the mandible of a Lophius Piscatorius (Angler).—Mr. Ross Wallis.

A molar tooth from an Indian elephant.—Mr. W. A. Maggs.

J. LEWIN PAYNE, Curator.

Chapel News.

PREACHERS IN CHAPEL, MARCH 15—30.

Sunday, March 16.—Rev. W. J. House. Rev. P. H. Bown, S. Anne's, Limehouse.

Sunday, March 23.—Rev. H. F. Le Fanu. Rev. P. H. Bown.

Tuesday, March 18.—8.15 p.m., Canon Brameld, Vicar of St. Stephen, Lewisham.

Holy Week Services.—Monday, Tuesday, Wednesday and Thursday—Holy Communion, 7 and 8.45 a.m. Address at 8.15 p.m. by Rev. H. F. Le Fanu.

Good Friday.—Litany and Meditation, 7 a.m.; Matins and Ante-Communion Service, 9 a.m. Three Hours' Service, 12 to 3, conducted by the Rev. Hyla Holden, All Saints', Poplar.

Evensong, 5 p.m.

Guy's Arms.

A SHIELD, hand painted in oils and gold, on metal $4\frac{3}{4} \times 3\frac{3}{4}$, mounted on shaped bevelled oak panel $7\frac{1}{2} \times 6\frac{1}{4}$. Suitable for the Library or Consulting Room. This is correctly copied from the original Arms supplied to the Hospital by the College of Heraldry. Published and delivered post free, price 21s., by the Art "Rilievo" Association, 34, Paternoster Row, London, E.C. May also be obtained from the Librarian, Guy's Hospital.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee :—

Clinical Assistants.—Messrs. W. H. Bowen, C. Tessier, G. T. Wrench, F. L. Thomas, H. W. Brown, W. G. Parker.

Clinical Assistant in Medical Out-Patients.—Mr. L. H. Moiser (Dr. Bryant).

Obstetric Dresser.—Mr. A. P. Piggot (April 1st).

Dressers in the Throat Department.—Messrs. A. C. Osborn, C. H. Robertson, G. F. Humphreys, F. H. Parker, W. C. Lewis, G. E. Malcomson.

Assistant Surgeons' Dressers.—Messrs. C. E. Iredell, K. Black, G. Carlisle, F. G. Goble, W. T. P. Meade-King (Mr. Lane); P. R. Bolus, H. Mann, C. D. Pye-Smith, E. H. B. Milsom, C. S. Morris (Mr. Dunn); J. W. Dadd, M. B. Taylor, H. O. M. Beadnell, S. C. Bowle (Mr. Fripp); F. P. Hughes, P. A. Peall, B. W. Lacey, O. Black (Mr. Steward).

Medical Ward Clerks.—Messrs. A. E. F. Kynaston, M. G. Louisson, F. B. Lowe, B. Moiser, R. P. Rowlands, B. H. Stewart, H. T. Bell Walker, L. H. Frankenberg, R. A. Greeves, E. Lloyd, O. V. Payne, G. A. Ticehurst, G. Nunn, F. Rogerson, R. St. G. Seagrove, A. M. Webber, R. D. Bridger, R. Franklin, W. S. Orton, R. M. Rendall, C. J. S. Dismorr, C. P. Harvey, H. H. Jenkins, A. V. Maybury, M. J. Mottram, G. C. F. Robinson, J. E. Spiller, J. D. Thomas, A. F. Hertz, E. C. Myott, F. W. Morton Palmer, L. J. J. Orpen.

Assistant Physicians' Clerks.—Messrs. P. P. Cole, H. H. Carter (Dr. Shaw); G. H. Rees (Dr. Washbourn).

Surgical Ward Clerks.—Messrs. A. M. Roome, J. M. Barrionuevo, A. M. Benett, G. H. Cheyney, D. Isaacs, W. Reeve, W. N. May, E. W. Routley, C. W. Ponder.

Aural Surgeon's Dressers.—Messrs. B. Churchill, D. Forsyth, T. H. F. Roberts (May–June).

Assistant Surgeons' Clerks.—Messrs. R. Felton, J. McF. Pollard (Mr. Dunn).

CIVIL.

BATCHELOR, F. S., F.R.C.S. Eng., has been appointed Assistant Surgeon to Dunedin Hospital, New Zealand.

BERRY, H. POOLE, M.B. Lond., has been re-appointed Medical Officer of Health to the Grantham Corporation.

FRY, A. CRADDOCK, M.A., M.B., B.C. Cantab., has been appointed Honorary Assistant Surgeon to the Essex and Colchester Hospital.

JACOBS, J. M. C., L.D.S. Eng., has been appointed Honorary Dental Surgeon to Queen Adelaide's Dispensary, Pollard Row, Bethnal Green.

SWAYNE, WALTER CARLESS, M.D. Lond., L.R.C.P. Lond., M.R.C.S., has been appointed Professor of Midwifery at University College, Bristol, *vice* Dr. Aust Lawrence, deceased.

NAVAL AND MILITARY.

SURGEON PHILIP N. RANDALL is promoted to be Staff-Surgeon.

SURGEON-GENERAL H. S. MUIR, M.D., C.B., is placed on retired pay. He was in the Afghan War of 1878–80, including the action of Shahjui, was mentioned in despatches, and received the medal granted for the Campaign. He was made a Companion of the Order of the Bath in 1900. He had but recently retired from the post of Deputy Director General.

LIEUTENANTS H. P. W. BARROW, L. HUMPHRY, and H. D. PACKER, R.A.M.C., are promoted to be Captains.

SURGEON-CAPTAIN W. RENDALL, Dorset (Queen's Own) Imperial Yeomanry, resigns his commission, and is granted the rank of Surgeon-Major, with permission to wear the uniform of the regiment on retirement.

MR. CHARTERS JAMES SYMONDS, M.S., is appointed Surgeon-Lieutenant in the 4th County of London (King's Colonials) Imperial Yeomanry.

SURGEON-LIEUTENANT A. E. LARKING, M.D., 1st Volunteer Battalion the Buffs (East Kent Regiment), is promoted to be Surgeon-Captain.

Guy's Hospital Out-Patients' Tea Fund, December 31st, 1901.

DR.	RECEIPTS.	£	s.	d.
To Balance brought forward		87	17	6
„ Subscriptions		116	1	9
„ Collected by Hospital Workmen		3	13	3
		£207	12	6

CR.	DISBURSEMENTS.	£	s.	d.	£	s.	d.
By Refreshments		38	0	10			
„ Toys		10	4	1			
„ Crackers & Lights, Animated Photo Show, Flags and Decoration		13	15	9			
„ Fees to Servants, Police, Postages, etc.		6	5	4			
„ Printing and Stationery ...		1	6	6			
					69	12	6
„ Special Donations—							
„ Maternity Samaritan Fund on 1900 a/c		10	0	0			
„ The Haven, ditto		10	0	0			
					20	0	0
„ Guy's Hospital to maintain a Cot, on 1901 a/c ...		25	0	0			
„ Maternity Samaritan Fund, on 1900 a/c		15	0	0			
„ The Haven, ditto		15	0	0			
					55	0	0
„ Reserve on Deposit in hand of Hospital		30	0	0			
„ Balance at Bankers ...		33	0	0			
„ Total Balance in hand carried to next Account ...					63	0	0
					£207	12	6

Audited and found correct,

CHAS. H. WELLS.

February 25th, 1902.

Medicine for the Million.

(In this week's *Free Lance* there is a compressed mass of horror, entitled "The Drugs of Death; an Interview with a Chemist." So startling and appalling is the account—which we have no reason to believe to be anything but veracious—that that we commissioned the most reliable of our staff to gather evidence on his own, so to speak).

. . . The Dispenser seized me by the arm, and crushed me into a corner where the weird drama could be seen by me, unseen. There was an air of suppressed excitement, of feverish restlessness, all the more accentuated by the dim light, and the death-like silence. Shadows, dim ghosts of men, hovered here, there, everywhere. Suddenly, at a little window that served as a counter, a face appeared, old, withered, wretched, that of a man who dare not think of his past, who fears the present, and dreads the future. My companion groaned. "What is it?" I asked. "That old man—a victim of the awful hot boracic habit. Night after night, with a punctuality that is in itself appalling, he comes for that drug. Sometimes he demands the lotion; sometimes he takes the prepared lint. Oh, it is terrible! terrible!" Just then a dispenser burst into tears, and was led, sobbing, away. The old man's place at the window had been taken by a young girl, whose sallow face and hazy eye spoke eloquently of some drug devil—some pharmacopœial monster that had sapped her soul. "And she?" I asked, in faltering accents. "One of the most inveterate and most hopeless of the devotees of this terrible curse. She is a white mixture maniac. Bottle after bottle, with fearful insistence, crushing out her very being in its devilish grasp." He buried his face in his hands, and sobbed like a child. Then I saw an old woman, whose temples were streaked with silver, searching and searching here, there, in every nook and cranny of the dispensary. "She," said my friend, in a voice thick with emotion, "is an old habitué of this place. She has learnt that in the sale of that frightful drug, Ext. Malt. Ferrat., some is of necessity dropped on the floor, and she, now ruined in health, and purse, spends many hours scraping and sweeping the floor, till she has obtained enough for a single hypodermic injection." I could gaze no longer on this living inferno. I staggered to my feet and even as I went forth I saw the young and the old clutching, struggling, screaming, aye even praying with a tremulous and pitiable earnestness for one more dose of the drug, were it Gent. et Sod., or the more awful Hyd. cum Cret.; I staggered out, I wanted air, air—the pure breath of heaven on my fevered brow. Away, away, only to leave this place. My companion had long since dissolved into tears and was now weeping drearily on a heap of blue wool. With one last look on the most terrible curse of this age I turned and went forth into the black night thinking, thinking, thinking.

THE BALLAD MONGER.

Reviews.

The price of books submitted for review should in every case be stated.

Diseases and Injuries of the Teeth. By Morton Smale, M.R.C.S., L.D.S., and T. F. Colyer, M.R.C.S., L.R.C.P., L.D.S. Second Edition. Revised and enlarged by T. F. Colyer. (Longmans Green & Co., 1901.) Price 21s. net.

The first edition of this work was published in 1893. Since that time many advances have been made in dental surgery and pathology. Therefore it was quite expedient that a second edition of so popular a book should be put before us, bringing the whole subject quite up to date, and this Mr. Colyer has certainly done.

We still hold the opinion that the title of the work was a mistake in the original instance, as there is much more in it than the title implies.

It is now a much larger work than before, but nevertheless none too full. There are many books of reference, but few reliable text-books in dental surgery, and this

new edition before us is sure, therefore, to gain even more popularity than before, both with students and dental practitioners, and parts of it might also be read with great advantage by many general practitioners.

As Mr. Colyer tells us in the preface, this edition has been almost entirely re-written, and consequently many advantageous changes are seen in the work. The nomenclature is very much altered in places, that of the diseases of the alveolo-dental membrane being the most striking. "Exostosis" and "Absorption" have been replaced by "Productive Periodontitis" and "Rarifying Periodontitis" respectively, and "Pyorrhœa Alveolaris" by "Acute and Chronic Suppurative Periodontitis." These new terms are certainly more rational explanations of the conditions to which they apply, but nevertheless we cannot help thinking that they will never entirely replace the older and more convenient nomenclature.

The table of contents and index are excellent, and the former especially is a great improvement on the old work.

The most formidable additions and enlargements are as follows:—An entirely new chapter on "Bacteriology of the Mouth," has been written for the book by Mr. Goadby. This is good and very necessary, but a little too long and full of technicalities for the average student. A rather shorter and more concise chapter, merely detailing the facts as at present known on the subject, would have been, we think, quite sufficient. The chapter on "Caries" has been well revised, with the more modern views of different individual points expressed. The "Treatment of Caries" has also been much enlarged. This is a difficult subject to discuss in such a work as the one before us, as there is practically no limit to it, but it is kept well within bounds and is much to the point. In illustrating gold filling, we think fig. 440–4, copied from the first edition, to show the method of packing soft gold cylinders, are a little deceptive to the uninitiated and should have been altered. Inlay work and crown work are only lightly touched upon, and rightly so. A few general remarks on the latter subject are well worth perusing. The chapter on "Abnormalities in Position of the Teeth," has been also very much enlarged and is good and valuable, a striking feature of this chapter being the profuseness of model photographs as illustrations.

There are very few or no faults to be found throughout the whole book, which is excellent in every way. Speaking of local anæsthetics, however, we should have liked to see Eucaine discussed a little more, as it has undoubtedly now obtained a prominent position as a local anæsthetic. We should also like to point out that Cocaine *Hydrochlorate*, is now properly termed Cocaine *Hydrochloride* in the B. P.

Many cases are cited throughout the book to illustrate different points, and each with a very definite object.

A salient feature in all text-books is ease of reading, and this one surpasses many others in that respect and is remarkably pleasant reading, and we feel sure it will improve its already prominent position.

The Urine: In Health and in Disease, together with its Chemical Examination. By H. Aubrey Husband. (Published by E. & S. Livingstone.) Price 1s.

This concise little guide to the examination of urine has proved so popular that a fourth edition has been recently published. In addition to a careful revision, new matter has been added; the question of albuminuria in relation to Life Insurance is now touched on. The book is well illustrated by diagrams and will be found most useful as a pocket book.

First Aid to the Injured and Sick. By Warwick and Tunstall. (Published by John Wright & Co.) Price 2s. 6d.

Although handbooks on "First Aid" are continually being published, this volume will be found one of the most useful of its class. The first part deals with the construction of the human frame, giving brief sketches of the joints, bones, blood and its circulation, etc., and so serves as a good foundation for the better understanding of Part II. which describes the application of bandages, treatment of hæmorrhage, and other points of practical importance. The chapter on poisons is clear, and the immediate treatment can be seen at a glance. The book is well illustrated and we would especially recommend it to nurses.

Elementary Bandaging. By Pye and Carwardine. (Published by John Wright & Co.)

This book has reached its ninth edition, which speaks well for its popularity. New illustrations appear, the importance of which cannot be undervalued in a practical book of this character. It will be found a most useful and concise handbook.

Sport.

Rugby Football.

GUY'S v. LONDON.

INTER-HOSPITAL RUGBY CUP. SECOND ROUND. REPLAYED-TIE.

After the first indecisive match in which each team scored 8 points, our men approached this game with rather more diffidence and a full determination to use their best endeavours. They were without the services of Harrison at full-back, his place being taken by Pye-Smith, but were otherwise at their full strength. There was a good attendance, the weather was propitious, and the Richmond Club ground in excellent order when a start was made at three o'clock on Friday, 28th

February. The London kick-off went into touch, and was recalled, then, after an exchange of kicks, Guy's rushed to their opponents' twenty-five yards' line, where a good round of passing between Payne, O'Brien and Morgan ended in the last named attempting a drop at goal which was, however, unsuccessful. Our attack was mainly on the left wing, and Alcock, going strongly, despite a damaged knee, was tackled on the London line. Our passing was, for a time, a little loose, both Payne and Alcock being offenders in this respect, but the game remained in London quarters until their forwards came away with a fine rush which was stopped by Thomas and Alcock. Neutral play followed until Payne, getting well away from a scrimmage, dribbled down to our opponents' line, but Gibson, outstripping him in the race for possession, succeeded in kicking the ball dead. After the kick out London rushed down to the centre, and close play followed on our side of the mid line, until a good forward rush brought them near scoring, as our forwards were not yet showing the dash of the opposing pack. London got the ball away from the scrum occasionally, but their passing was not clean, and O'Brien again transferred play to mid field by a judicious kick into touch. Glendinning, securing the leather smartly from the line out, found touch in the London twenty-five, but off-side play on the part of Thomas gave them a free kick which brought relief.

A high tackle by Crimp shook up Payne for a time, but he soon resumed, and effected a pretty dribble towards the enemy's posts. Glendenning also got in some good foot work, but kicked too hard, and enabled the London full-back to relieve with a high kick which was taken by O'Brien, who essayed a kick at goal which almost succeeded, After loose forward work Payne took the ball well from a scrimmage, feinted prettily to the right, then passed across to Alcock who scored after one of his characteristic runs along the touch line on the left; finally dodging round behind the posts Morgan converted without difficulty. Receiving the kick-off Pye-Smith found touch in mid field, and play was for a time in neutral ground, where a display of acrobatic tumbling by Glendinning created a diversion. Some good passing between Payne, Wetherell, Alcock and Glendinning ended in the last named being run into touch in goal. A forward rush by London gave them more of the game, but a rare bout of passing on the part of Payne, Alcock, McEvedy, O'Brien and Morgan gave the last named his first opening; running down the touch line he swerved in prettily and scored about ten yards from the corner flag, taking the kick himself, he sent the ball rather wide to the right. After a series of spasmodic attacks by the London forwards who never lost heart, but were rarely dangerous. A passing run by Wetherell, O'Brien and Alcock caused Guy's to attack, and Thompson, breaking away from the scrum, gave a difficult pass to McEvedy which was fumbled; as the result of a forward rush Cutler scored, and Morgan converted with a beautiful kick which just topped the bar, half time arriving with Guy's 13 points n hand.

Payne showed up prominently after the resumption of the game, but passed forward. Offside London play gave us a free kick, but O'Brien's drop at goal was unproductive. Payne again got well away, but was not backed up, and his pass was intercepted by a London three-quarter, while a mark by Crimp assisted them. Thompson was given offside, and Pye-Smith returned the resulting free kick, the London full-back mulled, and was tackled finely by Anderson, who picked up and passed to Morgan. London then broke away, invading our quarters, and play ruled slow for a time. Pye-Smith made his first mistake by misjudging a kick, but O'Brien got back and stopped a dangerous rush, and soon after again tried a left foot drop at goal, but without success. Give and take play between the packs ensued, and then Payne passed to Morgan, who was well tackled within ten yards of the line. London relieved by good back play, but Cutler, succeeding in marking after one or two unsuccessful appeals, by a fine kick transferred play to London quarters. Scrambling play followed, and Glendinning gave another display of ground and lofty tumbling. Alcock made game attempts to charge over, but, in fending off Gibson, dislocated his thumb and had to retire, Thomas taking his place in the three-quarter line. A piece of combined work between Glendinning, Ward and Lawry almost enabled the last named to score, while McEvedy and Morgan also looked dangerous, but the latter's pass was intercepted, and London relieved the pressure, and soon afterwards nearly scored as a result of Pye-Smith missing the ball, but McEvedy was able to kick it dead. Fast forward play ensued, and a five yards' scrum took place in the London lines, but a free kick afforded them relief. After this the game became slower, as London tried to cut their losses by keeping it close. Guy's, however, worked to within fifteen yards of the line, but Gibson and Crimp showed sound defence, and no side was called without further addition to the score. Team :—

Guy's.—C. D. Pye-Smith (back); E. Morgan, Alcock, A. O'Brien, P. McEvedy (three-quarters); M. C. Wetherell, Payne (half-backs); H. A. Cutler, T. P. Thomas, R. C. Lawry, A. R. Thompson, B. Glendinning, Ward, E. H. B. Milsom and Anderson (forwards).

GUY'S v. HARLEQUINS.

This match took place at Wandsworth on Saturday, March 8th. The Harlequins kicked off, and Guy's at once attacked, and Walker made a good dribble, and, picking up, passed to Thompson, who transferred to Milsom, who ran over the line and scored a try, which, however, was not converted into a goal. Shortly after the kick-out the Harlequins rushed the ball to the other end of the field. Some tight scrums took place, and from one of them the ball was well heeled out by our opponents. Good passing amongst their three-quarters resulted in Pumphry getting the ball, and he succeeded in getting between Pye-Smith and the touch line and scored a good try far out from which no goal was kicked. Shortly before half time, Pumphry again scored, though

he was stopped for a short time by Pye-Smith, who did not succeed in hauling him down.

In the second half, play was chiefly confined to the forwards, and many scrummages took place in mid field, from one of which Hamond broke away with a good dribble, and, although he went into touch, was allowed to proceed, and scored a try, beating Pye-Smith in a race for the ball. A goal was kicked. After the kick-out, Guy's were forced to act on the defensive for the rest of the game, Trail being very noticeable for his good saving work. An uninteresting game ended in the Harlequins' favour by 1 goal 2 tries to 1 try.

REMARKS.—Of the team which usually has played for Guy's, seven were absent—some from injuries, some from pseudo-injuries, some, we regret to say, suffering from the effects of slackness. The forwards played fairly well individually, but lacked cohesion. Of the backs, Walker and Louisson were the only ones who played even fairly.

GUY'S v. KING'S.

INTER-HOSPITAL CUP-TIE. SEMI-FINAL ROUND.

This match was played at Richmond on Tuesday, March 11th, and ended in a hollow victory for Guy's by 8 goals, 5 tries, 54 points to nil. Guy's won the toss and decided to defend the Kew end of the ground. King's kicked off and Wetherell returned the ball into touch at half-way. The forwards then rushed the ball up into our opponents' twenty-five, and Milsom following up a kick of McEvedy's collared the King's back over his own line, and from the scrum which ensued the ball went across to Louisson, who was playing left wing three-quarters, who scored wide out. Morgan failed with the kick. From the kick-out play settled in the King's twenty-five, and Ward showed up well with a good run. A mark to King's gained no ground, and Lawry coming through the scrum with the ball, dribbled up, and by keen tackling kept the play well on our opponents' line. McEvedy put in a good run, and passing to Morgan the the latter was forced into touch in goal. So far Guy's had been playing a poor game altogether, the passing being uncertain, and very little ground being gained by it. Scrums were formed on the line, but it was some time before Morgan got tries at the corner. He converted this try with a magnificent kick from the touch line.

The tackling of the King's men was very keen, but superior combination began to tell, and McEvedy scored with a good run; the kick failed. Some good kicking by Louisson followed, and then Payne put in a grand run, but McEvedy was heavily brought down on taking his pass, and the game was stopped for a few minutes. The forwards next broke away, and the genial Welshman, Thomas, picking up, added another try to his long list already scored in cup-ties; O'Brien failed with the kick. Immediately afterwards, O'Brien scored under the posts after a dodgy run; Morgan goaling. King's next got a mark, and by good kicking invaded our twenty-five for the first time. This did not last long, as Wetherell got well away, and passing to O'Brien, the latter added another try, Morgan converting. Half-time was called with Guy's leading by 3 goals 3 tries to nil.

On resuming, King's rushed up and got well away, but Lawry came to the rescue with a good tackle. McEvedy was again laid out and went full back, Pye-Smith coming three-quarters. The former was immediately called to relieve with a good kick into touch. From the scrum Pye-Smith got possession, but was forced into touch in goal. O'Brien made an abortive attempt to drop a goal, but soon after a good round of passing ended in Morgan again getting in, the same player converting. King's now bucked up and looked like scoring, but Morgan, picking up in our twenty-five, raced down the touch line and scored under the posts, and converted. Payne next put in a great run into the King's twenty-five, and Pye-Smith scored. Immediately afterwards the same player dropped a neat goal, and on resuming scored again, but just as Morgan was taking the kick, attention was called to the touch judge who was frantically waving his flag on the far side of the field for touch. McEvedy next picked up at half-way, and running right through the whole team, scored under the posts; Morgan goaling. Morgan again scored just before the whistle blew for no side, but the kick failed, Guy's retiring winners as stated. Team:—

GUY'S.—C. D. Pye-Smith (back); E. Morgan, A. B. O'Brien, P. F. McEvedy, M. G. Louisson (three-quarters); O. V. Payne, M. C. Wetherell (half-backs); H. A. Cutler, R. C. Lawry, A. R. Thompson, T. P. Thomas, R. G. Anderson, E. L. Ward, E. H. B. Milsom and S. McK. Saunders (forwards).

Referee—Mr. P. Coles.

Touch Judge—Mr. Tom Morgan.

GUY'S 2ND XV. v. MERCHANT TAYLORS' SCHOOL.

Played at Bellingham on March 8th. Score: Merchant Taylors, 2 goals, 1 try; Guy's, 3 tries.

Guy's won the toss and took advantage of a slight wind blowing. Merchant Taylors, however, soon got the ball into Guy's territory, and about two minutes from the start grounded the ball wide. The kick at goal failed. Play after this was mostly confined to the Guy's twenty-five, till Barber, dribbling in fine style down the field, scored wide out. This was not improved on, and from the drop-out Guy's returned the ball to home territory. Play was of an extremely scrambling nature, and just before half-time the School got in again, this time the major points being added.

On resuming, the School were dangerous several times, but Barber again saved the situation by repeating his previous performance and scoring wide. The kick failed, and shortly after a kick was awarded to the School. The kick was, however, charged down and the ball taken to the School quarters; a kick by the opposing back relieved and Bridger fumbling the ball, failed to get in a return kick. Again the school scored and converted, but this

was quickly followed by Guy's scoring a third try. Nothing futher was scored before time. Team:—

Guy's.—R. Bridger (back); S. L. Pallant, E. N. Jupp F. W. Hogarth, J. Goss (three-quarter backs); R. Willan, H. Barber (half-backs); H. Watts, T. W. Featherstone, L. Doudney, W. Ball, H. G. Gibson, H. J. Hills (forwards).

Remarks.—Guy's, although three short, should have done much better, both tackling and passing being very weak.

Association Football.

GUY'S v. LONDON.

Semi-Final Cup Tie.

This match was played at Winchmore Hill on Wednesday, March 12th. The ground was in excellent condition, and the game from the start was fast, but neither side became very dangerous till towards the end of the first half, when London had somewhat the better of the game and Collins had to leave his goal several times to clear; our backs and halves, however, were playing a good game and the teams changed over without any score being recorded.

At the commencement of the second half our forwards got together and with some good combined efforts looked dangerous, Norton finally scoring with a brilliant shot after a good run. A few minutes later Norton headed a second, while shortly afterwards the London forwards ran up and scored, the score being now two goals to one in our favour, with twenty-five minutes to play. Some good runs and centres by Peall on the left wing, and Wragg on the right, kept the ball in our opponents' half for most of the remainder of the game, and though we only added one more goal, which Litchfield headed from a corner kick, we were playing a winning game all the while, the final result being a victory for Guy's by three goals to one. The game was a pleasant one and a fast one throughout. In the second half the team played one of the best games they have played this season, while in the first half, though the forwards were rather ragged, the backs defended well, Edey being perhaps the most conspicuous. Team:—

Guy's.—E. A. Collins (goal); T. Edey, A. R. Wilson (backs); P. Pedrick, A. F. Denning, L. H. Frankenberg (half-backs); E. Wragg, P. C. Litchfield, H. Barber (captain), E. L. Norton, P. A. Peall (forwards).

GUY'S 2nd XI. v. ST. THOMAS'S 2nd XI.

Junior Inter-Hospital Cup.

This match, the first round for the Junior Cup, was played at Honor Oak Park on March 4th, and resulted in a win for the home team by 2 goals to nil. Winning the toss, St. Thomas's played with the wind, and for the first quarter of an hour the exchanges were even. Then the visitors commenced to press, and had hard luck in not scoring, the ball passing several times across the mouth of the goal. At length, however, after some good work in the centre, Wilson scored the first goal for Guy's from a scrimmage in front of goal. After this the game was even, the home back division playing a steady game. Turner made one or two good saves, and Crofts cleared well.

On going over, Zorab, who had been playing a good game at right half, hurt his leg and had to retire, but Guy's continued to press, Chignell putting in some good shots. Several good runs were made by each wing, but the centres were not utilised. Chignell scored the second goal by a good bit of individual play. After this the game became rather slow, both teams towards the finish showing evident signs of poor condition. Team:—

Guy's.—Turner (goal); Crofts, Leeming (backs); Smith, Foster, Zorab (halves); Messent, Wilson, Chifnell, Barlow, Harland (forwards).

GUY'S 2nd v. BART.'S 2nd.

Junior Inter-Hospital Cup.—Semi-Final.

This match was played at Winchmore Hill on March 10th, and resulted in an easy win for Guy's by 8 goals to nil. Guy's were not at full strength; Leeming was suffering from "Battenitis," and several other regular members of the team being ill, great difficulty was experienced in raising a full team. The substitutes, however, all played well, and deserve credit for turning out at the last moment. For the first ten minutes play ruled fairly even, but after one of the Bart.'s backs had diverted a shot from Chignell past his own goal-keeper, Guy's pressed continuously, and further goals were scored by Wilson (2) and Reader. Bart.'s started the second half well and gained a corner, but after Messent had scored from a good centre by Harland, went all to pieces, and Guy's doing as they liked scored again by Reader and Chignell (2). The game thus ended: Guy's 8, Bart.'s nil. The whole team played well on a greasy ground, and if they keep fit should make a good fight for the Cup in the Final. Team:—

Guy's.—Turner (goal); Crofts and Jones (backs); Cole, Foster and Milton (half-backs); Messent, Wilson, Chignell, Reader, Harland (forwards).

Births.

CLOWES.—On March 7th, at "Grantley," Wotton-under-Edge, Glos., the wife of Ernest F. Clowes, M.R.C.S., L.R.C.P., of a son (prematurely).

TYSON.—On March 3rd, at Folkestone, the wife of W. J. Tyson, M.D., F.R.C.P., F.R.C.S., of a daughter.

WALKER.—On February 24th, at Odos Solonos, Athens, the wife of Alfred W. Walker, L.D.S., of a son.

Ed.—D. G. G.

Contents.

	PAGE
RETIREMENT OF MR. HOWSE	125–126
POSTERIOR BASAL MENINGITIS: Clinical Lecture by Dr. Taylor	126–133
CORRESPONDENCE: A Literary Society	133
TYPES	134
PASSIM	135–137
L. A. DUNN, ESQ., M.S., F.R.C.S.	137–138
PAPERS BY GUY'S MEN	138
OBITUARY: P. T. Manson...	139
ACUTE BRIGHT'S DISEASE	139–141
IN LIGHTER VEIN	141–142
SPORT: Rugby Football—Guy's v. St. Mary's. Association Football—Guy's v. St. Mary's; Guy's v. London ...	143–144
APPOINTMENTS	144

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

April, 1902.

Tues. 1.—Messrs. Jacobson and Fripp's take-in; Drs., P. W. Hammond and F. C. Robinson; Cl., W. H. Bowen.

Preliminary Scientific (L.D.S.) Exam.

Cambridge Third M.B. Schedules to be brought to Medical School Office for Signature.

First Conjoint Exam. begins.

First Part of Cambridge D.P.H. Exam. begins.

May Appointment List opened.

Thur. 3.—Messrs. Lucas and Lane's take-in; Drs., H. M. Woodward and T. C. Lucas; Cl., H. W. Brown.

Second Conjoint Exam. begins.

Fri. 4.—Test Exam. for First Professional Exam. for L.D.S. Eng.

Tues. 8.—May Appointment List closed.

Final Conjoint Exam. begins.

Second Part of Cambridge D.P.H. Exam. begins.

Thur. 10.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. E. Brayne and C. E. Adams; Cl., W. G. Parker.

Guy's Hospital Gazette.

MARCH 29, 1902.

Retirement of Mr. Howse.

ALTHOUGH it has been known for some time that this year would be brought into prominence in the history of Guy's by the retirement of Mr. Howse from his position of activity as Senior Surgeon to this hospital; nevertheless, now that the time has come, none the less do we feel our great loss. No longer shall we see the familiar figure in the Colonnade, round the Wards, in the chair amid the instruments. Guy's men of the present day will remember through the future these last days of the carbolic spray, all will certainly always appreciate the honour reflected on Guy's by the appointment of Mr. Howse as President of the Royal College of Surgeons. As we look through the history of our Alma Mater from the sixties, even if we only study surgery superficially, we repeatedly find Mr. Howse's name in connection with the great advances in surgical science which have taken place during this period, not only in our own hospital, but throughout the world. It was he who introduced Listerian methods into Guy's, marking that epoch of rapid change from great risk and high mortality to comparative absence of danger; we who have only lived in these days of aseptic surgery, when suppuration after operations is almost unknown, can hardly appreciate what one who has had so vast an experience in operating must have passed through during that epoch. Mr. Howse at once saw the possibilities in the new methods, and after a visit to Joseph Lister in 1868, commenced the use of antiseptics in this hospital, modifying the method of application according to his own views from time to time; again, it was at a time when anxiety was felt after every operation, when the public still preferred considerable discomfort and death almost to the risk of the knife, that Mr. Howse became the first to undertake excision of the varicose veins and to suggest the removal of varicoceles; others speedily followed his example, thus proving the good results of the treatment. His skill in the

operation of excision of the knee, especially for tubercular disease, everyone recognises; his experience in this having earned for him a name so popular, that with all respect he is known to every Guy's man by it.

We must leave abler pens than ours to describe Mr. Howse as a surgeon; carried away with enthusiasm, we have trespassed already, but we must just mention that from the date of his entry into Guy's, he gave promise of the future career of success and distinctions he was to have, achieving honour for himself and so for this hospital, finally obtaining his M.S., qualifying for the Gold Medal.

His house-surgeons, dressers and ward clerks will always remember his kindness and patience. A question from any one of them always brought forth from his stock of experience and vast fund of knowledge practical points applicable to the case discussed. He would listen patiently to any view expressed, and analyse carefully, explaining the pros and cons. When going round, though he might differ in opinion on the treatment ordered, he would always give it a fair trial if possible. Responsibility was always placed by him where it was sought and worthy to be placed. The slack man got what he deserved—nothing. House-surgeons have passed their six months without ever feeling themselves deprived of any advantages accruing to their post. Mr. Howse was always so considerate and kind that it was impossible to feel uncomfortable; he was as a friend to those working with him. Sports he is not supposed to take a great interest in, but we have seen worthy representatives of his family present on important occasions cheering Guy's on. To his patients in the wards he was invariably most considerate, and often could he have been seen speaking for some considerable time, stating the possible risks and benefits of operation, placing everything in a fair light that they might choose according to his advice. Very rarely did he ever speak of past events in his own career, or of what he himself had done. Had Mr. Howse only written more of the things he has done he could have gained even more fame than he has at present. No one has more deserved to bring honour on himself and Guy's. All have congratulated him most heartily on becoming President, and all hope to see his services recognised during this year of the Coronation. May the post he holds be his for some time, and may we still see him occasionally and note the interest taken in Guy's by its latest Consulting Surgeon.

Posterior Basal Meningitis.

CLINICAL LECTURE BY DR. TAYLOR.

February 15th, 1902.

Gentlemen,—This is the case of a child, sixteen months of age, admitted for convulsions. It is a full-term child, and it was quite healthy until six months ago, when it had diarrhœa. Since then it has wasted a great deal. The diarrhœa stopped recently. The patient was retching and suddenly had a fit, going black in the face, the fit lasting ten minutes. Then the patient was brought up here without delay and was taken in.

Condition on admission.—In the front surgery the child was comatose, livid, collapsed and pulseless. The eyes were turned up and the pupils minutely contracted. There were no twitchings. While being examined it improved considerably. The pupils dilated and the child appeared to be better. A few rhonchi were heard in the chest. Nothing was found abnormal in the abdomen. On admission to the ward the patient was given a mustard bath and put to bed. Soon after being put to bed, patient had another fit similar to the first, but soon got well again. The temperature was 103°, pulse running, respiration 32.

December 19th. Patient has had a series of attacks of semi-coma to-day, with upturned eyes and contracted pupils and Cheyne-Stokes breathing. The temperature remains high. Patient has retention of urine and has been constipated since admission, but the rectum is found to be empty.

21st. The condition remains much the same. His eyes were looked at with the ophthalmoscope yesterday and found to be quite normal. The constipation continues, but the abdomen is

supple, and patient now passes water freely. There is slight cough. The temperature was 105·4° this morning, and came down to 102° this evening.

23rd. To-day a well-marked internal squint of the left eye is noticed, and there is some retraction of the head. *Tache cérébrale*, Kernig's sign and retraction of the abdomen are absent. The temperature is very high.

27th. Patient's condition continues much the same. The squint is not nearly so marked. The retraction of the head is very marked, but there are no other signs of meningitis, and there is no optic neuritis. The bowels are well opened. The temperature still remains very high, being 105·2° this morning.

31st. The condition is much the same. There are no fresh symptoms. The temperature continues high, and food is taken badly.

January 4th. The patient lies on one side with the head retracted.

8th. Still in the same position, no response to ordinary stimuli. When turned over on the back the child does not cry or make any sounds or movements whatever. On auscultation râles can be detected in the right middle lobe of the lung. Patient's pupils react to light.

17th. Pyrexia and cough continue.

22nd. Patient still lies with his head retracted and his mouth open. Râles can be heard all over the chest. The cough is persistent and also the high temperature. The heart sounds are normal. On palpation of the abdomen, the spleen and liver can be felt below the costal margins.

27th. Patient is in much the same condition. The râles have cleared up a little, however, but the cough is much the same. The temperature has come down the last three days, and has been fluctuating between 99° and 100°, and 96° and 97°.

February 1st. Patient still takes his food badly. A sore which had formed on the left ear has healed up.

February 3. Patient has developed an abscess over the left mastoid process during the last two days, and a quantity of pus has been let out by incision. The patient's temperature has been subnormal for the last day, though the pulse and respiration are still high.

5th. Improvement generally is not very obvious, although there are no râles to be detected now in the chest. The temperature is still low.

11th. Patient's condition continues to be the same and the wound caused by opening the abscess has healed up.

We have here the six weeks' temperature chart—from the date of admission (December 18th to January 28th). You will see that the temperature is very high in the first week, running up frequently nearly to 106°; in the second week it ranges from 102° to 105°; in the third week from 100° to 104°; in the fourth week gradually coming down to 100° or 101°; in the fifth week the temperature was frequently still up to 102°, and in the sixth week it became subnormal. But the child's condition is not entirely satisfactory yet. He still lies in bed very unobservant of things around him; one can scarcely say unconscious, although very nearly so. The head is still retracted; the patient is very much emaciated; there is a slight amount of rigidity of his limbs, his legs are still curled up and his arms flexed, and he lies on his side just as he is placed by the nurse. Since February 7th, he has been fed with a nasal tube because he took food so badly. So that though he has recovered from the greater part of the fever, he is an apathetic individual, dulled as to all his senses, and presenting still a symptom which you will have observed mentioned several times—retraction of the head, or approximation of the occiput to the spine.

This is no doubt a case of meningitis. The prominent features of the case are these: that there has been prolonged fever, with emaciation, and retraction of the head, in an infant sixteen months of age.

A diagnosis of meningitis rests generally upon these conditions—that the patient is commonly febrile, and has certain symptoms indicative of general intracranial pressure, and special localising symptoms indicating interference with particular nerves.

As regards the first of these features, our patient has had fever for a period of six weeks at least.

Secondly, the symptoms of intracranial pressure that we get in ordinary cases of meningitis are headache, vomiting, optic neuritis and general convulsions, and these also occur as a result of tumour in the brain. In meningitis, headache is a common symptom over a long period; vomiting is common at any rate early; optic neuritis frequently occurs, and convulsions happen from time to time.

The specialising or localising symptoms that occur in meningitis are mostly paralysis, or loss of special sensation, paralysis occurring in consequence of interference with, or compression upon, certain nerves connected with the brain at the part where the meningitis is existing. Or convulsions may occur under similar circumstances or in consequence of some similar lesions. For instance, in tubercular meningitis, and in some cases of ordinary suppurative meningitis, you may get paralysis of the ocular muscle, or of the facial nerve, or of the muscles of one side in consequence of inflammation involving the motor centres on the opposite side.

In this case you will see that the symptoms under either of these heads are not very numerous. Headache we know very little about. The child is very young, and we have not been able to ask it whether it has got headache, and it has not shown, even by constantly applying the hand to the head, that it has this particular symptom. Optic neuritis was not present at first; it has never been observed, and when I examined the eyes yesterday or the day before it was not present. Convulsions have occurred. So that we have chiefly vomiting, or retching and convulsions, both in the early stage of the disease, as manifestations of general intracranial pressure, amongst which, however, we must not forget the dulness, apathy, and almost comatose condition which is constantly present. As regards specialising symptoms we have only got this—that the patient has pronounced retraction of the head towards the spine. This symptom was not observed when the patient first came in, but it has been persistent ever since. Now it is admittedly a little less prominent than when it was first observed. On the strength of these facts, simple though they may be, we have come to the conclusion that the patient has meningitis.

One may often have a difficulty about the diagnosis of meningitis, more especially in infants. Even if many of these symptoms were present in a more aggravated form than what they are now, we might not easily arrive at a conclusion. For instance, with regard to the convulsions which occurred early, we know that in infants and young children convulsions occur at the onset of acute fevers. Scarlet fever, measles, whooping-cough and acute pneumonia, may all be ushered in by general convulsions. Headache, drowsiness and flushed features will sometimes be present with convulsions, and these may all be due to otitis or inflammation of the ear. That is a very important consideration indeed, and very much, as I shall show, concerned with or mixed up with the subject we are dealing with now. Inflammation of the middle ear or otitis media is a very common event in children, and when it occurs it frequently gives rise to high fever and to headache, which a child may localise by constantly applying the hand to one side of the head. If the pain is very intense and the child is excitable, there may be convulsions which, combined with the other symptoms, may readily give you the impression that meningitis is present. Some such cases have given rise to symptoms lasting for four, five, or six days, and then at last when the child has appeared to be at its worst, screaming in a way that is considered to be almost characteristic of meningitis, the abscess in the ear has burst through the membrana tympani and the child has got better; showing that the disease was otitis, and not meningitis.

With regard to older children, it is a familiar fact that in them, and even in adults the recognition of tubercular meningitis is sometimes very difficult, for this reason—that the disease is confounded with typhoid fever. It may be hoped, of course, that as we have more means, especially in the presence of the Widal reaction, for discriminating typhoid, this mistake will not be made so often as it has in the past.

But we cannot rely solely on that method of investigation, because it is not generally in the first days of typhoid fever that the Widal reaction can be safely depended upon. If we have to wait for ten days in order to get results, a confusion of the two diseases may still occur. You might ask why it is that two apparently distinct diseases, diseases which have their starting point, at any rate, in such different parts of the body, should be so readily and so frequently confounded together. The explantion of it is this—that although typhoid fever arises from bacterial lesions primarily in the intestines, the toxines connected with these bacteria are present in other parts of the body also. One of the first symptoms of typhoid is headache, and the headache is sometimes very intense. I have known a boy with typhoid fever cry out, "Oh, my head, oh, my head!" in considerable distress about the seventh or ninth day of the illness. Then associated with the headache you frequently get marked drowsiness arising from the toxines present. For that reason there may be a suspicion of tubercular meningitis, especially if the patient has hitherto been a delicate patient and if there is a family history of tubercle.

Further reasons for that confusion are these. While the cerebral or head manifestations of typhoid are pronounced in the way I have described, the abdominal manifestations may be very indistinct. You know that in typhoid fever patients may have no spots until the fourteenth day, and not even then. You know that diarrhœa may be represented only by one or two loose motions, and then the patient may suffer from constipation afterwards. So that you can see how occasionally a case of typhoid may be mistaken for a case of tubercular meningitis. And, conversely, tubercular meningitis may be mistaken for typhoid because the headache may be so intense in both cases; because in many cases of tubercular meningitis the intracranial pressure does not at first cause vomiting, and does not necessarily cause convulsions, and may not cause optic neuritis; or the optic neuritis being there, may be overlooked or neglected; and because until quite late in the disease the localising signs of paralysis are not present. Therefore it may readily happen, and it does happen, that a case of tubercular meningitis is actually mistaken for typhoid. I could give many instances, both where a mistake has been committed; and where judgment has necessarily been suspended until the development of further symptoms.

In cases of meningitis in general, the deciding physical symptoms or signs are those which indicate local disturbance of the brain, that is, an interference with one particular part of the brain. If in a case supposed on rather inadequate grounds to be typhoid, there should appear a squint, or paralysis of an ocular muscle or of the muscles of the limb, or convulsions in some isolated part of the body, such an occurrence generally points to the brain as the seat of mischief.

In the present case, persistent retraction of the head and early convulsions are the signs we have to consider. Probably retraction of the head is not of so much value as facial paralysis or ocular paralysis. Retraction of the head occurs sometimes under conditions of irritation other than that of a definite inflammation. But undoubtedly meningitis is the most common cause of retraction, and it is the condition in which the retraction is most marked. Convulsions also occur under many toxic conditions, for instance, as the first signs of pneumonia, or scarlatina, or other infective disorders in children, but rarely or never in typhoid.

The other signs which commonly assist the diagnosis of meningitis, at any rate in the tubercular and suppurative forms, are the following: Retraction of the abdomen, which is common in tubercular meningitis, but not peculiar to it. The same symptom occurs in the later stages of slowly-growing tumours of the brain. Another symptom is *tache cérébrale*. If you rub your finger over the surface of the forehead or abdomen, a broad red line is produced in every place you touch, by the paralysis of the minute vessels. The persistence of these red marks for two to five minutes is a phenomenon which is most striking in meningitis, but which occurs also in some cases of typhoid, and other pyrexial conditions. Then there is

optic neuritis, which is common both in tubercular and suppurative meningitis.

There is another sign of which a good deal has been said lately, the so-called Kernig's sign. When this child first came in, Kernig's sign was not present, but a day or two ago a slight degree of this condition could be observed. Kernig's sign is this: As long as the patient is either lying on his back, or as long as the thigh is extended in a line with the body, the leg can be extended upon the thigh. That is to say, as long as there is extension at the hip-joint, extension can be obtained at the knee-joint. But when the hip-joint is flexed either by sitting the patient up in bed, or while the patient is recumbent, by raising the limb so that the thigh is at right angles with the body, then it will be found that complete extension at the knee cannot take place. When this sign is well marked you find that you cannot straighten the knee beyond an angle of 120° or 130°.

I ought to remind you of another thing, and that is, that in certain children who have long suffered from profound errors of digestion and assimilation, there may be a combination of drowsiness, irritability, emaciation, stiffness and rigidity of the limbs, which presents certain resemblances to some of these conditions of meningitis, and which was called many years ago spurious hydrocephalus.

We have no reason to believe that this is the case here, and we will conclude that it is a case of meningitis. The question is, What variety of meningitis is it?

Inflammation affecting the dura mater is called *pachymeningitis*; inflammation affecting the pia mater is called *leptomeningitis*. Pachymeningitis may be acute or chronic, and purulent or hæmorrhagic. The purulent form may arise from injury, or in association with purulent leptomeningitis; the hæmorrhagic forms have often been seen in elderly persons of drinking habits.

Much more frequent are cases of leptomeningitis, and here we see the obvious preponderating influence of micro-organisms in its production. There are a good many well recognised organisms that are concerned in the production of meningitis, and their relations to the different forms are given in this table:—

Suppurative meningitis	caused by	streptococci. staphylococci.
Tubercular meningitis	,,	tubercle bacillus.
Epidemic cerebrospinal meningitis	,,	diplococcus intracellularis of Weichselbaum.
Posterior basal meningitis	,,	an allied diplococcus.
Pneumococcal meningitis	,,	diplococcus pneumoniæ.
Syphilitic meningitis	,,	syphilitic microbe (?) or toxine (?).

All these forms of leptomeningitis—and that does very nearly exhaust them—are referable to micro-organisms or toxines, and they can be often recognised, and to a certain extent distinguished from one another.

In the present case we can exclude readily some of these. For instance, we can exclude suppurative meningitis, a condition which has always been recognised as differing in many points clinically from tubercular meningitis.

If you believe you have a case of suppurative meningitis, you must know that you have got either an injury to the skull or some disease about the external or middle ear, or disease about the nose or the nasal fossæ or the ethmoid bone, which will explain the entrance of these organisms into the cranial cavity. Just as in abscess of the brain, so in suppurative meningitis of this type, you should remember that the organisms must have facilities for getting there, and you ought to be ready to explain their arrival before you hastily make a diagnosis of suppurative meningitis.

The child has had sores about it, but they have only been secondary. There was a sore on the ear, and subsequently an abscess over the mastoid process. But these are local inflammations which have taken place in the ward, in the case of a child who is emaciated and whose powers of resistance are at the lowest ebb, and who requires the extremest care in nursing.

We can exclude epidemic cerebro-spinal meningitis. The features which distinguish it

are the fact of its epidemic occurrence, the production of skin eruptions, and the greater prominence of spinal symptoms than are present in this case.

Pneumococcal meningitis also I think we may exclude. It is very frequently a rapid event. A very good instance of it occurred in Clinical ward two years ago, when a woman, about forty years of age, suffering from mitral disease, was admitted with an attack of pneumonia. She had high temperature, bronchial breathing at one base, and a murmur at the mitral orifice—indications of pneumonia and mitral disease, and possibly of ulcerative endocarditis. One morning early she was seized with convulsions, and our first impression was that these were the result of some particles being driven off from the mitral valve and impacted in a cerebral vessel. She became comatose and died about twelve hours after the first convulsion; and was found post-mortem to have pneumonia, ulcerative endocarditis and meningitis, which was obviously of pneumococcal origin. In the present case I think we may exclude such a condition, partly because we have no evidence of infection with pneumonia, and partly because the duration of two months is unusually long.

Syphilitic meningitis I think we may also exclude. It is certainly rare in an acute form, and there is no evidence of syphilitic poison in this case.

That leaves us with these two considerations —tubercular meningitis and posterior basal meningitis. No doubt these two conditions have been frequently confounded together. I remember that years ago, when acting as Physician to the Evelina Hospital, one often saw cases in which, after death, there was found a basal meningitis, but in which we failed to find those tubercles and tubercular masses which are commonly present in typical cases of tubercular meningitis. Nevertheless, we classed them all as tubercular meningitis. It requires a certain amount of genius to distinguish a fresh disease. That genius was supplied by Dr. Gee and Sir Thomas Barlow, who showed clearly that there were cases of meningitis which were not tubercular and which presented features distinguishing them from the ordinary tubercular instances.

The resemblances between them are these. They both occur in young children. It used to be said that tubercular meningitis was commoner between the ages of two and five than under two years of age. Some more recent figures show that it is very common in the second year of life, but that it is not very common in the first year of life. On the other hand, posterior basal meningitis is common in the first as well as in the second year. So that in a very young child from sixteen months to five years, it may be either form of the disease, and on the whole posterior basal meningitis occurs in younger children than does tubercular meningitis.

In both the meningitis is situated at the base of the brain and not at the vertex, which is the more common seat in suppurative, and pneumococcal, and epidemic cerebro-spinal meningitis. Tubercular meningitis is commonly anterior basal, as well as posterior basal, whereas posterior basal meningitis is posterior basal only. Tubercular meningitis produces as its characteristic distinguishing feature, paralysis of the ocular muscles. That is effected, of course, by the inflammation in the anterior part of the base of the skull, in connection with the nerves which arise from that part of the brain and pass into the orbit to innervate the ocular muscles.

In posterior basal meningitis the lymph which is collected, and which is not a pus so much as a yellowish-white, semi-solid lymph. This lymph is mostly on the pons varolii and the base of the cerebellum and the upper part of the spinal cord. And you will see that the signs which we have, so far as they are distinctive, do indicate a posterior basal connection rather than an anterior basal connection.

The chief phenomenon is retraction of the back of the head, and this must be due to irritation of the nerves at the upper part of the spinal cord. Posterior basal meningitis is distinguished also, especially from tubercular meningitis, by the absence of many of the characteristic signs

of that disease. You may remember that in descriptions of tubercular meningitis you get a very long list of all the possibilities, and very full and dramatic accounts of what can happen in that disease. Do not believe that you will always find them in every case, for there are cases in which many are absent. But you will remember vomiting, a flushed face, squint, retraction of the abdomen, *tache cérébrale*, sighing respiration and Cheyne-Stokes respiration, rapid irregular pulse, increasing drowsiness, delirium, and finally convulsions, with paralysis of the ocular muscles, or of the muscles of the limbs, and then death.

Now the main feature of this case is this retraction of the head. In fact, these cases when they were first described separately, were described as cervical opisthotonos, or backward flexion of the spine in the cervical region.

The onset of this disease is commonly in one of two or three ways. Either it is accompanied by vomiting, or convulsions, or retraction of the head. In this case we had, first, vomiting, then convulsions, and very shortly afterwards retraction of the head. In other cases retraction of the head has been noticed first. Dr. Lees and Sir Thomas Barlow show that in one fourth of the cases recorded by them, retraction of the head was the first symptom, in one-third vomiting, and in one-third convulsions; in the remainder screaming and sleepiness.

The retraction of the head is not the only feature; there is in many cases some spasm in other parts of the body, especially extensor spasm of the back, arms and legs. In other cases there is opisthotonos of the lower spine, as well as the cervical opisthotonos. In others again, but less commonly, with the retraction of the head, there is flexion of the body and limbs. There is also in some of these cases strabismus or squint, and sometimes nystagmus or oscillation of the eyeballs. But the optic discs are very generally normal, and there is an absence of the optic neuritis, which is so common in tubercular and suppurative forms. Nevertheless, amaurosis or blindness is frequently present, and may persist for a long time during convalescence.

Convulsions other than the tonic spasms already described, are not frequent in the prolonged course of the disease. Nor is a definite local paralysis frequent—for instance, paralysis of a limb, or of the face. The knee-jerks are present and often increased.

The breathing is sometimes in the condition known as Cheyne-Stokes' breathing. It is here so described. Dr. Lees and Sir Thomas Barlow have recorded another variety of breathing which differs from Cheyne-Stokes in that there is not the same alternation of rapid deep breaths with slow shallow breaths, with gradual change from one kind to the other; but a period of rapid respiratory movements alternates with a long period of complete rest (or apnœa). They give to it the name of "cyclical breathing."

The temperature is variable. Sometimes, especially in cases that are fatal, the temperature rises very high. Patients have temperatures of 106° and 107°, especially in acute rapidly terminating cases, but in slower cases the pyrexia is usually slight. In this case we had a temperature of nearly 106°, but the temperature is now much lower at the same time that the child is slightly improved.

The condition of the ears is of much interest. As a fact, otorrhœa is not a common symptom; but it is well known that otitis in infants and young children gives rise to symptoms very like those of meningitis, namely, intense headache, screaming, drowsiness, fever and even convulsions. Moreover, the organism of posterior basal meningitis must get into the brain by some or other channel, and it is believed that this channel may be the naso-pharynx, eustachian tube and tympanum.

Now, it is desirable that one should examine the ears in these cases, and see that they are perfectly right. In this case I have had the ears examined, and at present they are perfectly normal. In every case in which you *suspect* meningitis, it is important that the ears should be examined, and in the event of anything being found wrong with them, especially if there be any inflammatory lesion of the tympanum, that should be treated; because if that is relieved possibly the whole of the symptoms may subside and recovery may ensue.

Of course, if that should happen in this case, the question arises, "Was this really a case of meningitis, or only a temporary condition of otitis?" At any rate, whichever way you look at it, the first consideration is to make sure whether you have or have not got a relievable condition of the ears by which a further spread of the condition may be prevented, as it is quite possible that even supposing it was a condition merely of otitis, infection might spread to the brain and so induce a definite meningitis.

The duration of these cases is much longer as a rule than those of either suppurative or tubercular meningitis. Lees and Barlow found an average of seven to eight weeks in thirty fatal cases, with a minimum of three weeks and a maximum of five weeks. During this long period very considerable emaciation takes place, and the children are often extremely wasted at the time of death.

The prognosis is an exceedingly bad one. The greater number of cases are fatal, but they do sometimes recover, and I think we shall possibly see a successful termination of this case, the temperature having come down, the retraction of the head having relaxed a little, and the child's nutrition, though very bad still, not getting worse of late. We manage to feed the patient by means of the nasal tube, though we should rather see the operation a little more natural.

In rapid cases not very much hope is to be obtained from the treatment. Leeches have been advised in acute cases; they should be applied behind the ears. Iodide of potassium has been advised and we have given this child small doses, 1 to 2 grs. a day from the first.

If the patients get well, they convalesce very slowly, and certain of their senses may be materially damaged. They may recover their sight and their hearing very slowly, or not at all; and they may recover very slowly the power of walking because of the impairment of their motor functions in consequence of the prolonged lesion of the nerve-centres.

Another important thing is this. Local inflammatory disease at the base of the brain, and at the back of the base of the brain, resulting in the obliteration of the anatomical foramina by which the arachnoid spaces communicate, may bring about a chronic hydrocephalus by accumulation of cerebrospinal fluid. This is a serious result of the disease, and may require separate treatment afterwards.

Correspondence.

To the Editor of Guy's Hospital Gazette.

A Literary Club.

Dear Sir,—"To be all things to all men" is, I think, a worthy motto for a club, but there are, amongst us, so many men, having so many and so various ideas, opinions, and seekings, that to rise to such an ideal were well nigh impossible.

Some years ago, started in a small way, continuing and ending in that same way, there was a literary society within the walls of our hospital, select, exclusive, fearing to be great; it neither asked for or encouraged the average man, who lacked sufficient enthusiasm to be entirely enveloped by the mists and vapours of the most recent cult, vogue, or ism.

I would, however, appeal through the Gazette to the men in the hospital, whether there is not a great deal to be gained in a pleasant and interesting way, by a study of the literature of our country which is so crowded with material worthy of our assimilation, whether it would not be well to endeavour during the next winter session to organise a Literary Society and by mutual aid to educate ourselves a little more widely, so that conversation may pass beyond the hospital, sport, and the weather.

It has been said men and women range themselves into three classes or orders of intelligence; you can tell the lowest class by their habit of always talking about persons, the next by the fact that their habit is always to converse about things, the highest by their preference for the discussion of ideas.

The importance of our examinations is so constantly present to our minds that we forget, that success in after-life depends not so much on our medical, as on our social ability, and a rapier, or pistol is not now the weapon most useful with which to engage our rival as an epigram or a retort.

Gibbon, the historian, had a rival in a French physician for the favour of Lady Elizabeth Foster. "When my Lady Elizabeth Foster is made ill by your twaddle," said the doctor, in a loud voice, "I will cure her." "And when my Lady Elizabeth Foster is dead from your prescription," said the historian," I will immortalise her."

In conclusion, sir, may I ask you to open your columns for the expression of your readers' opinions as to the advisability of starting in the autumn a Literary Society, and for the discussion of the best plans for working such a scheme.—Yours truly, ARTHUR W. ORMOND,

Hon. Sec. Students' Club.

Types.

VII.—The Colonial.

"One from the ends of the earth. . . Mother be proud of thy seed.
Court are we feeble or few? Hear is our speech so rude?
Look are we poor in the land? Judge are we men of The Blood?
Doubtless ye are the people absolute strong and wise."

Kipling.

Fresh from the fertile fatherland, young, expansive, and self-reliant, the New Zealander sits himself on London Bridge and, surveying the ruins of Guy's Hospital, asks the propellant "peeler" the way to the Newest Nursing Home.

He is the scion of an illustrious house. His father came over with "Jack Rabbit" the Conqueror; his genealogy is treasured in the National Archives, and his crest resembles "broad arrow," denoting, doubtless, a knightly descent from the mediæval archers.

His education has been peculiar, but extensive. His early youth was spent "amidst the great unknown," among "the great unwashed." In the intervals of biting bananas as big as cucumbers, he would playfully hurl the boomerang and lessen the overcrowding in the neighbouring bush settlements.

He rode horses before he could write, and most men would rather ride camels than read his writing. He learnt to swear before he could speak, and to this day he displays the advantages of careful home-training.

Handy at "picking up trifles," a hereditary characteristic, he learnt more than the rough riders meant to teach, and after mastering the sheep-shearer's slang, and exhausting the station library, his too-ready repartee and over-apt quotation caused a painful scene one morning at breakfast, and he was consigned by his grieved mother to the schoolmaster, whom he speedily consigned to perdition, and by whom he was painfully consigned to bed.

Schooling ended, hooded with the M.A. degree (Ballarat), a gentleman by birth and breeding, a man by education, he was after some delay destined for the "finest profession on earth,"—item, the worst paid.

His popularity on ship was only equalled by his energy ashore. Poor, but proud, he worked his passage out—in the card-room. His virtues were many, his vices few and manly, and he smokes any *given* number of cigars.

Arriving at Charing Cross, he asked for the hospital, and for the first time he was sent home from "up West" in a cab, and he was assured by the Dean that he had "taken a very wise course." Formidable at football, demonstrative at smokers, ardent in affection, his knowledge of the world, frank face, convivial talents, and forcible but picturesque language, early secured him a place in the "best set," and he earned with equal facility the signatures of the Dean, the approval of Handcock and the friendship of "Commish" (2, 6).

Full-fledged in worldly wisdom, and keenly alive to the secret of power, this "many-sided" and "*much-enduring*" man took tea with the sisters, sent flowers and chocolates to the nurses, and hobnobbed with the Staff.

Aged somewhat from wickedness, weariness, and worry of exams., his fatherly respectability and demure, yet roguish eye, together with a staid demeanour ensured his well-earned and popular appointment of H.-P.

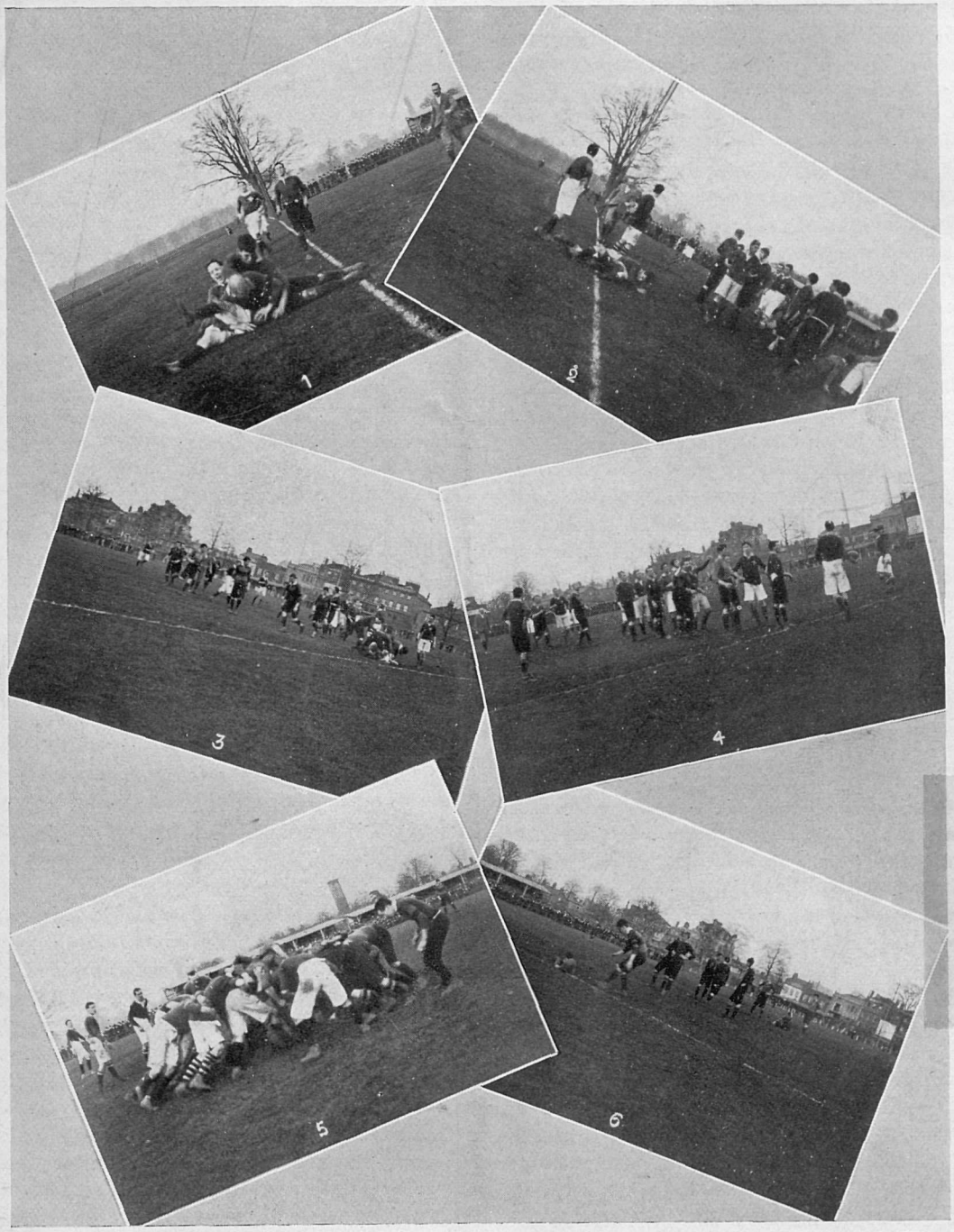
He came into his appointment like an heir into a heritage and reaped the fruit of his sowing; no scandals and few curses came home to roost.

The "safe man" of the staff became the respectable G. P. to the Hostel, and the consultant of the ward-maids. To his fatherly care fathers committed their student sons, and mothers entrusted their nursing daughters.

Although "those whom the gods love die young," still at the early age of 35 he became President of the Residents, and, despite (?) the Psalmist, he has flourished like a green bay-tree.

He leaves us as he came, in the heyday of his prosperity and popularity, with many friends (some of whom would fain stick closer than a *brother*), and without a stain on his character, "but then some men have such luck."

The Hospital is now to let.



1. A DISALLOWED TRY. 2. GUY'S SCORE. 3. HELD. 4. A LINE OUT.
5. A SCRUM. 6. A KICK AT GOAL.

Inter-Hospital Rugby Final.—Guy's v. St. Mary's.

(Guy's in Dark Knickers, St. Mary's in White).

Passim.

During the past fortnight Guy's has been honoured by a private visit from the Prince and Princess of Wales. Their stay was no perfunctory flying visit, for the tour round the various wards and theatres lasted over two hours, and the keenest interest was shown in the progress made in the work of renovation since their previous visit. It is sincerely to be hoped the general public will profit by this splendid example of practical interest in hospital work. May they no longer be content to dismiss the urgent appeal for help by annually murmuring a few platitudes on the good work done for the sake of suffering humanity as they drop a shilling or two into the collection on Hospital Sunday.

We are very glad to be able to confirm the rumour that the Prince and Princess have also graciously consented to open the Nurses' New Home. As at present no details have been settled we would suggest that the wise and natural thing is to combine the opening with the Annual Prize Distribution; any attempt to make the latter a separate function is almost bound to result in the garden party being overshadowed by the more important event, and consequently falling flat.

The news of Manson's cruelly sudden death came as a great shock to his many friends up here. It seems such a short time since he was reading his paper on Malaria before the Physical Society and talking enthusiastically on his coming voyage. The expedition in which he was engaged at the time of the sad accident, was sent out by the London School of Tropical Medicine, its object being to investigate tropical diseases, more particularly beri-beri. Great things were expected, Christmas Island offering exceptional opportunities which had hitherto been much neglected. For although the island has only been annexed to the British Crown for some twenty years, it is already peopled with men working to develop its great mineral resources; ships are frequently to be seen anchoring in Flying Fish Cove, and substantial house are rapidly being built.

The informal dinner given to Mr. Dunn on the eve of his departure "Up West" to that "Mecca of medical men" (Gibson), was the hearty success everyone anticipated it would be. Long and loud were the cheers that greeted the President on rising to propose the guest's health. Mr. Gibson, plunging in medias res, threw formality to the winds and spoke of "John Dunn," the friend and trusted counsellor of every man in the College. After thanking the Residents of the College for the silver cigarette box they had just given him, Mr. Dunn said that although the wardenship offered an unique opportunity for getting to know "the boys" and making many a life-long friendship, the bed of roses was not without its thorns (voice from the back "charities"). During the evening many wild rumours got afloat, one forcasting the Warden's domestic future, while another appointed a well-known patron of Italian art as the new Sub-Warden.

We understand that Dr. Eason has been elected Warden of the College, and that he will shortly come into residence.

It has been said that people with only one idea are the pest of society. In a community consisting of men more or less interested in the one and the same subject, there is every chance of these tedious bores flourishing with the exuberance of a Jonah's Gourd. Therefore, we welcome our correspondent's suggestion that a Literary Society might be organised. Looking at the proposal from a purely utilitarian standpoint, there can be no doubt such a society would be the very best antidote to a circumscribed, one-sided development. One does not want to always be breathing the same confined atmosphere, listening to a ceaseless chatter about cases. Doubtless some will be ready to maintain that sport affords a sufficient relief from this scholastic pedantry and that lovers of books and pictures—in short the cultured man we recently "typed"—are but effeminate weaklings worthy only of pity and contempt. But there is really no incompatibility between muscular

and intellectual education, for although we have our Le Galliennes with their velveteen cycling suits and "ready made velveteen names," thank goodness we also have our Richard Jefferies.

Again, that worthy but uninspired type, the plodding "pot-hunter" will perhaps plead that he has no time for anything beyond his dull monotonous grind at work, upon which he foolishly believes his future success solely depends. Mr. Ormond wisely points out in his letter "social ability" counts for much in the race for popularity and professional success. The leading members of any profession are always men of culture, men of wide interests, ready and able to talk on subjects quite apart from their special branches. Further, it is a false economy of time to be always at the mill, as Rare Ben Jonson said, "The mind is like a bow, the stronger by being unbent." A writer, who was that rare combination a philosopher and a man of the world, once said all innovations should be made as *Time* works its changes, and though there is no idea of taking any active steps until next winter, we hope that readers will nevertheless let us know their views on this question.

The quarterly appointment list once more has caused its usual flutter in our Hospital dove-cot and settled the fate of a large number of applicants. Messrs. Wall and Davidson become House-Surgeons, and Messrs. Dobson and Greenfield House-Physicians. The latter are succeeded at Out-Patients by Messrs. Trubshaw and Pearson, while Messrs. Gray and Odgers become Assistant House-Surgeons in the Front Surgery.

The Cup-ties of the football season have come and gone, and although not fulfilling all our hopes, still we are left the winners of two out of the three cups, including that great prize the Rugby Cup, so we have every reason to feel pleased with ourselves.

Our Rugby Club concluded one of our very best seasons on Monday week, as we all anticipated, by winning the much prized Cup. This is as it should be, for our present team is certainly the pick of the Hospital teams, and one of the best, if not the best, that has ever represented Guy's. The list of victories during the season is only marred by a very few defeats, and our win over St. Mary's in the final, by seventeen points, was a fitting termination to it. Our team was fully represented and Alcock again appeared on the wing, having recovered sufficiently from his recent accident. The game was full of incident, particularly during the first part, when our opponents by keen tackling managed to prevent us scoring. Superior combination, however, told its inevitable tale, and we ran out winners by one goal and four tries to nil. To the Captain and the whole of the team we offer our heartiest congratulations on their play during the whole season and on what is dearest to the heart of Guy's men, the winning of the Cup.

Last Monday the fates were quite against us in our match with St. Mary's in the final cup-tie of the Association competition. The weather, after promising to be fine, turned out wet and gusty, and accidents spoilt our chances of victory. The team started in good form, and played a vigorous and scientific game, when about a quarter of an hour from the start, Denning fractured his clavicle and, of course, had to retire from the game. Immediately after Norton broke through and scored a magnificent goal. Mary's quickly equalised by a rather doubtful shot, and after pressing till half-time, crossed over with a lead of two to one. The beginning of the second half was the great feature of the game, as for some time our forward line, although short and lacking combination, were continually attacking, and our hopes revived, but only for a while, for then Pedrick was almost incapacitated, being unable to run. Still, our men played a really hard game, and it was not till late in the match that Mary's put on three goals in rapid succession, giving them the victory by five goals to one. Although beaten, our team deserves the greatest credit for the fine uphill fight that they made till the last. The amount of work put in by everyone was immense,

particularly in the defence, Frankenberg being especially noticeable. It is no good speculating as to what might have happened, but the game will be remembered by all who saw it as one of the pluckiest fights ever made for the Cup.

In the Junior Cup, however, fortune was kinder to us, and by defeating London by three goals to one the Cup was once more brought back to the Hospital. After many changes in the team during the season, a good side turned out for the final tie, and although lacking the dash of some of our former teams put a good deal more combination into the game than is usually seen, and gained its reward. The game was keen until half-time, and it was not till the second half that we had the game in hand. We have almost a surfeit of half-backs in the hospital this year, and in both teams the halves are exceptionally strong.

Our newly-formed Hockey Club made a good show against St. Bart.'s, who are considered a strong side, and were defeated by a goal to nil, and that only on playing extra time. Our side was considerably weakened by the absence of Wedd from illness. This is a good start for the first season in the competition, and we trust that it will be improved on next. We understand that the Hockey Association does not allow clubs to compete for a cup.

On Monday, March 17th, the victorious Rugby XV. were entertained to dinner by the Residents. One member of the team was unfortunately absent through injury, the other fourteen suffered severely from thirst, which, however, reacted to symptomatic treatment. After the usual loyal toasts had been drunk, the President, in a carefully prepared speech, proposed the health of the Rugby XV. This was received with great enthusiasm and musical honours. Mr. Cutler replied by saying that it was the proudest moment of his life; he then burst into tears. Mr. Wetherell then stood on his chair, gave a short lecture on "The Residents," their friends, morals and habits, where they came from, how they got here, and where they may expect to go to. He finished up by proposing their very good health. Mr. Geo. Lewin proposed "The Ladies," and said he didn't know what he had done to be called upon for this toast. Mr. Morgan blushingly responded for the fair sex. Mr. French then mounted his chair and insisted on making a speech. He told a tale about Mr. Cosmo Bonsor; three medical ward clerks were seen to laugh (they have all got extension). On adjourning to the Charities' Room songs were sung, and the cup was passed round.

The Annual General Meeting of the Students' Club will be held on Thursday, April 17th, at 4.15. Dr. Pye-Smith will be in the chair. The election of three non-resident students' representatives on the Committee has to be made.

L. A. Dunn, Esq., M.S., F.R.C.S.

The gulf stream of medical geography, which sets perennially north-westwards from the shores of St. Thomas's Street to the regions about Cavendish Square, has sent an eddying wave up Great Maze Pond, even to the doors of Guy's Hospital College, and carried off Mr. Dunn. In other words, the Warden of the College has "gone up West," and a new Warden reigns in his stead.

The matter-of-fact man will find in the Medical Directory the dates on which Mr. Dunn passed various examinations and took various prizes, together with the titles of his professional writings, and other details in which the matter-of-fact man sees the essence of life. The curious man may go to the Medical School Office and find, perhaps, how many lectures Mr. Dunn attended when a student—very likely to be surprised by the regularity with which Mr. Dunn attempted the futile task of "learning an exact subject by more or less inexact dissertations." With these matters, as being fully dealt with elsewhere, the present writer has little concern. It seems to him of more importance to try and realize what manner of man it is whom the inhabitants of the College have lost in their late Warden. It is said by those who remember Mr. Dunn as a

student that his characteristics then as now were a kind of deliberate seriousness, a resolute carefulness, which paused to think, but did not shrink from acting promptly on the thought. "Look before you leap" might have been his motto, had that method of progression commended itself to his mind as superior to the ordinary one of walking. Strange as it may seem to the junior men, there are still some of us about the hospital who remember Mr. Dunn as Demonstrator of Anatomy. In the dissecting-room the success of his teaching was as complete as the method of it was careful. It has been said that the best way of learning a subject is to teach it, but Mr. Dunn never gave anyone the impression of having adopted this system. Afterwards, in the wards and out-patient department, the same power of making men learn what he had to teach was conspicuous in him. Even those whose object seemed to be *not* to learn, had to carry away something with them, and that something was usually bound to stick—at any rate till after the examination.

But apart from his teaching, his personal influence with the junior men was quite remarkable, the more so in that men in their first two years may be said (with all due respect) to be more difficult to deal with than those who have had a longer course of hospital training. Their individual peculiarities are almost unknown to the authorities, their interests are vague and disconnected, as a group they have less cohesion than men of longer hospital standing; and to some of them the newness of their position is apt to be a little bewildering. But in spite of all this, Mr. Dunn held them together, led them, helped them, taught them several things besides anatomy, with an authority which was as complete as it was popular.

Mr. Dunn's influence with the students, both in the dissecting room and subsequently when Warden of the College, was undoubtedly due to his general and complete sympathy in all that concerned them, both individually and collectively. His characteristic manner is the expression of a very real and sincere interest in those whom he has to influence and control. In this connection it may be observed that though Mr. Dunn never took an active part in the cricket or football field, he has always been an interested and regular attendant at all the big matches. In fact, nothing which concerns the Guy's student has he ever considered as foreign to him; and many are the lame dogs which he has helped over stiles, both on the Victoria Embankment and elsewhere.

"Time forcibly reminds me," remarks the Ghost of Dr. Johnson; "that all things which have a limit must be brought to a conclusion;" among which things both this article and Mr. Dunn's wardenship must be reckoned. As to the latter, Guy's men may congratulate themselves that though Mr. Dunn has said good-bye to the College, he has not done the same to the Hospital and Medical School. It is true that many ties have been severed—on the 31st of next December, for instance, the late warden will be permitted to sleep undisturbed. The peaceful consultants in Portland Place do not, we are given to understand, usher in the New Year after the manner known to the Guy's residents. But after all, much remains: the influence Mr. Dunn has gained for himself among the students will remain, his teaching in the school will remain, his many friendships with past and present Guy's men will remain. That his new quarters may be all that he can desire, that his days may be prosperous and his path pleasant, that birds may be plentiful and sport good through many successive Octobers, is the sincere wish of his many friends both inside and outside Guy's Hospital College.

Papers by Guy's Men.

Hay's Reaction for Bile Salts. By A. P. Beddard, M.A., M.D., and M. S. Pembrey, M.A., M.D.—*British Medical Journal*, 22nd March, 1902.

Two Cases of Rare Orbital Tumour. By F. T. Paul, F.R.C.S.—*Ibid.*

Two Cases of Congenital Diseases of the Left Side of the Heart. By Theodore Fisher, M.D. (Illustrated). *Ibid.*, 15th March, 1902.

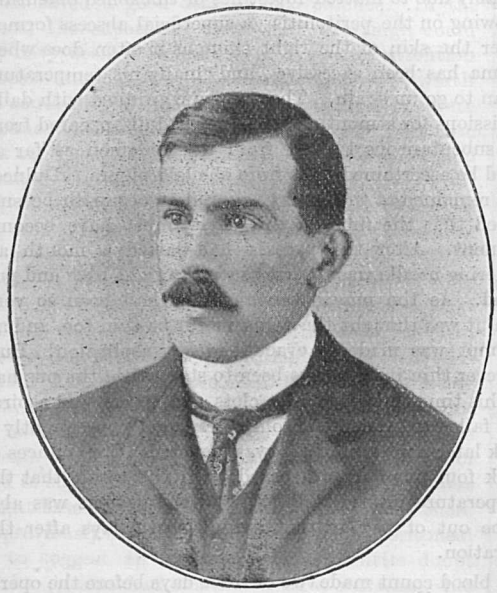
Case of Leucotrichia Annularis associated with Developmental and other Pigmentary Disorders. By G. Norman Meachen, M.B., B.S. Lond., M.R.C.P. Edin.—*British Journal of Dermatology* for March, 1902.

Obituary.

Patrick Thurburn Manson,

Born August 20th, 1878; died March 8th, 1902.

"That gallant spirit hath aspir'd the clouds,
Which too untimely here did scorn the earth."



The cabled report of sudden death always shocks one, but when the message, almost brutal in its brevity, refers to a dear friend who has so lately said farewell in the happiest of spirits, and with the brightest anticipations of the future, the blow seems more cruel, our loss harder to realise.

On the 3rd of January, Pat Manson left England with H. E. Durham, whom he was accompanying on an expedition to investigate certain tropical diseases in the East. On the 8th of March he died at Christmas Island, from a gun accident.

So on the lonely shores of this eastern island has passed away one of Guy's most beloved sons, one of the happiest spirits of our hospital.

Born in Amoy, China, on the 20th of August, 1878, Pat came home when about three years of age, and lived with his relatives at Dollar, Scotland, until his family arrived from China in 1889. After some time at a preparatory school at Harrow, he went to Harrow until he came up to Guy's in 1895. Taking his M.B. London in November, 1900, he left us to go to Aberdeen, partly to be amongst his own people, partly to have a thorough course of Pathology under Professor Hamilton, his father's friend. Then he went to the School of Tropical Medicine at the Royal Albert Docks, before leaving for his two years' cruise in the East, and South Pacific, which was to help to make him a fit assistant for his father, Dr. Patrick Manson.

So he died, cut off in the very springtide of his youth—a youth so full of honest endeavour, brilliant attainment, and promise of a more brilliant future. Mature beyond his years in mind and physique, he always impressed those who worked with him with his wholeheartedness, his clearness of thought, his distaste for inaccuracy and bluff. Full of energy and resource, steadfast of purpose, he was as enthusiastic in the field of work as in that of sport; while there was such a bright vein of gaiety in his nature that life was to him a source of perpetual enjoyment, and with this joy of living he infected all his surroundings—all his associates. No one who worked with him in the wards—no one who played with him in the Rugger teams of '99 and 1900, can think of him except as a trusty comrade, a genuine friend, a courteous gentleman.

In writing to us, his father says: "I have never liked to claim for myself what I do not hesitate now to claim for him—the most complete experimental demonstration of the truth of the mosquito malaria theory. All other experiments are open to some objections, his is perfect." This was the keynote of his character; honest himself, he demanded honesty in others, and was never grudging in his admiration for soundness of work, nor lacking in his contempt for all that was petty and base.

Acute Bright's Disease.

A paper read before the Physical Society by Mr. G. G. Davidson, B.A.

Mr. President and Gentlemen,—Cases of Acute Bright's Disease are not usually welcomed into the medical wards with marked outward manifestations of joy. There is a striking similarity about most of them, and one stereotyped report would describe them all pretty well. Exceptions, however, occur now and then, and about this time last year there was an exceptional case in the hospital. It began as an ordinary case of acute tubal nephritis, but the disease took such an unusual course that I think it is worthy of being brought before the notice of the Physical Society.

The patient was a young man of 22. There is nothing to note in his previous history except the following point, which may be important. When he was ten years old he was kicked somewhere near the right knee, and the injury was followed by an abscess on his thigh, which slowly got well. Five years later a second abscess broke out, apparently spontaneously, in the same place. These abscesses have left a large white scar on his thigh.

The illness for which he was admitted began on January 13th, 1901, with all the well-known symptoms of acute tubal nephritis. The patient observed his body swell and his urine diminish in quantity. He had some lumbar pain at night, and he felt unwell altogether.

When admitted he was found to have general anasarca, the scrotum and penis in particular being enormously swollen. He had ascites and hydrothorax. His urine contained albumen 14 per cent. and granular casts, but no blood. He is said to have passed about ʒxx. daily. His bowels were opened five or six times a day.

For the first five or six weeks of his illness nothing unusual happened. He lay in bed and slowly got worse and more waterlogged, until his skin in places gave way under the strain. Lineæ atrophicæ appeared on his abdomen, and also all up and down the right thigh, which was more swollen than the left, and clear serum oozed from the skin-cracks. The swelling of scrotum and penis became prodigious. His urine slightly diminished in quantity, but his bowels remained very loose. He did not feel particularly unwell, and was troubled principally by the mechanical discomfort of his œdema.

All this time his pulse tension continued very low, and he had no retinal changes.

It was not until about the seventh week of his illness that he seemed to pick up a little. The quantity of urine increased to about ʒxl.–ʒlx. daily, and the œdema began slowly to subside.

For about ten days he appeared, though very weak, to be on the way to recovery. He was then seized one morning (March 9th) about the end of the eighth week of his illness, with severe pain in the abdomen, and he felt very sick. The pain recurred once or twice and he vomited. The temperature was raised and he had pyrexia, with daily intermissions, for ten days. He was at this time passing a fair quantity of urine containing about 5 per cent. albumen.

It was thought that the abdominal pain might be due to tension from ascites, and on the evening of the day on which it occurred, paracentesis abdominis was performed. Nearly four ounces of a pale opalescent fluid, resembling the fluid of chylous ascites, was withdrawn. On standing, this deposited a large quantity of leucocytes. A chemical examination of it was made, and it was reported to be "serous, not chylous; to contain fibrin in quantity, also serum albumen, serum globulin and nucleo-albumin, together with traces of urea and extractives, and also soluble chlorides and sulphates of lime; to contain no cholesterin or fat." It was, in fact, an inflammatory fluid containing leucocytes, or in other words, thin pus.

A blood-count was made and showed—

R.B.C. - -	4,000,000	per c.mm.
W.B.C. - -	18,975	
Hb. - - -	30 per cent.	

Five days after the attack of abdominal pain the prepuce and scrotum began to slough, and in the next few days the albumen dropped from 5 per cent. to 2 per cent. to 1 per cent. to ·5 per cent., then to a mere trace, and finally quite disappeared. From March 21st, about the middle of the tenth week of his illness, to July 3rd, though the urine was examined regularly, no albumin was found. The urine was always normal in quantity and specific gravity, and contained a normal amount of urea.

He got on very well for about a fortnight after the paracentesis, and then came another bad week, eleventh to twelfth week. He developed a pleuritic rub in the left side; he got some more abdominal pain, and an irregular lump could be felt in the hypogastrium, presumably due to matted intestines or thickened omentum following on the peritonitis; a superficial abscess formed under the skin of the right thigh as it often does when œdema has been excessive; and finally his temperature began to go up again, The pyrexia continued with daily remissions for a month. The fluid had disappeared from the subcutaneous tissues, from the abdomen as far as could be ascertained, and from the left pleura. Dulness still remained at the right base, and it began to be suspected that the fluid in this cavity must have become purulent. After the pyrexia had lasted a month an exploring needle was inserted into the right base and pus found. As the pus in the abdomen had been so very thin, it was thought that this might be thin too, and an attempt was made to evacuate it by aspiration. But, however thin it may have been to start with, the pus had by this time thickened into clots and flakes, and aspiration failed to evacuate it completely, and consequently a week later a portion of rib was resected. Two ounces of thick foul pus were evacuated, with the result that the temperature immediately fell, and the patient was able to be out of bed in the evening three days after the operation.

A blood-count made two or three days before the operation shewed:—

R.B.C. - - -	4,500,000
W.B.C. - - -	18,000
Hb. - - -	40 per cent.

being a very slight improvement in the condition found six weeks previously, at the time when purulent peritonitis was discovered. The patient from the date of the operation for empyema made an uneventful recovery, though, owing to the state of weakness to which he had been reduced, it was eight weeks before he left the hospital. I saw him by accident about August or September, six or seven weeks after he had gone out. He still had a very slight discharge from his empyema, but he was stout and strong, and looked well.

This, then, was a case of acute Bright's disease, which ran a short, sharp course, and in which the nephritis began to mend about the seventh week, without having produced either the retinal changes or the cardio-vascular symptoms, which commonly occur when the disease is more prolonged. While the patient was recovering from his nephritis, he was attacked by a suppurating peritonitis and later by a suppurating pleurisy, which caused fever and very nearly killed him. He also had two fairly common complications of acute Bright's disease, one a severe one, viz., sloughing of the prepuce and scrotum; the other not very severe, viz.,

a superficial abscess on the leg which had been so œdematous that the skin had given way. The most astonishing feature of the whole case is the recovery of the patient.

In the treatment of the case, the established ritual was piously followed, and there is not much to be said about it. If it were always possible to be as wise before the event as after, then two things might have been done which were not done, and the patient might thereby have been saved a good deal of incovenience. In the first place, the superficial abscess of the thigh could probably have been prevented by a very strict attention to antisepsis and asepsis. It is probably always worth while in acute Bright's disease, when œdema is so severe as to produce skin-cracks, to dress the affected part with the most rigid surgical cleanliness. Bacteria easily find an entrance through the weak points in the skin, especially if serum is oozing from them, and the result may be not a mere abscess but a violent attack of erysipelas.

In the second place, the empyema might possibly have been cured by an early aspiration. It is very likely that the pus here, as in the abdomen, was thin to begin with. If aspiration had succeeded, the patient would have been saved from four to five weeks of fever, a mutilating operation, and a wearisome sinus. The condition might, I think, have been diagnosed earlier than it was. There was pyrexia to suggest inflammation, the condition of the blood to suggest suppuration, the cough and dulness at the right base to suggest the locality, and finally there was the previously ascertained condition of the peritoneal effusion to suggest an analogy. There is little doubt that if the patient had not had Bright's disease, the right base would have been explored a day or two after the pyrexia began. The existence of nephritis complicated the calculation. The patient was very ill and nervous, and thus a long delay occurred before it was decided to inflict upon him even the momentary pain which the insertion of an exploring needle into the pleural cavity involves.

With regard to the peritonitis, on the other hand, it is difficult to see how a correct diagnosis could have been arrived at. It is true that here, as in the case of the empyema, there were present pyrexia, leucocytosis, and local symptoms, especially pain; and it is possible that the intellect of a medical Sherlock Holmes might have found these data sufficient for deducing a correct diagnosis. But there are other causes of abdominal pain in Bright's disease besides peritonitis, which is, after all, a rare event. It might have been due to colitis or enteritis, by which the disease is sometimes complicated; and if this view had been adopted in the present case, there was the persistent diarrhœa from which the patient suffered to lend support to it. Fortunately for the patient, his abdominal pain was actually thought to be due to distension; paracentesis abdominis was performed, and this led to the discovery and alleviation of the real cause.

(To be continued.)

In Lighter Vein.

SURPRISE VISIT OF THE WARDEN.

Last Saturday the Warden paid a surprise visit to the College. As it was strictly a surprise visit, the President of the Residents received him in the porter's lodge and conducted him to the dining-hall, where he was entertained in a most charming manner. With characteristic generosity the President had issued invitations a few days previously to the residents (with a small r) to come and dine with him, only specifying that they footed the bills themselves.

Everything went off all right, with few casualties, and after the last Scotch woodcock had been consumed, the President was helped to his feet and spoke as follows:—"Mr. Warden and Gentlemen,—I have asked you here to-day to do honour to our departing Warden." (Tremendous applause). He then sang the honeysuckle and the bee, and attempted the lost chord. Frustrated in this, he asked the Warden if he smoked, and receiving a reply in the negative, presented him with a handsome cigarette box. The Warden then got up and said that he was deeply touched by the President's voice, and that it had quite ruined his digestion. He also said that he was not married and never had been. (Uproar). He was sorry to leave the boys, more especially as he should not hear any more smoking concerts. He loved harmony. Whereat the President attempted the lost chord again, still without success. Mr. Rowlands then got up and replied for the visitors. In a few well-chosen words he referred pathetically to Jane, and closed his speech in tears. Mr. Lewin then got up to address the House on a point of order. He understood that there were rumours about that he was to undertake the arduous and responsible post of Warden. He assured the House that it was a *canard*, and after calling the President a ——— ———, was suspended. The whole party then retired to the reading-room, where some round games were indulged in. In order to drown conversation, Mr. Holmes hit the piano as hard as he could and

Mr. Parrott sang. Next came some tableaux, the Ophthalmic H.S. appearing as the "Blind boy looking for his hat," and the Charities gracefully posing as "Italian Statuary."

Later on in the evening it was found that some of the men were playing bridge while their opponents were playing snap. This made progress rather difficult, so everybody got up and sang what he thought was "Auld Lang Syne." Mr. Thompson then danced a beautiful step-dance round himself, and in the confusion the Warden retired. Then a few of them went to bed, including

THE BALLAD MONGER.

University of Cambridge.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES, EASTER TERM, 1902.

PLAN OF EXAMINATION

(subject to alteration in details, of which due notice will be given).

THIRD EXAMINATION.

PART I.

Tuesday, April 22. 9 a.m. to 12 m.—Principles and Practice of Surgery (in the Senate House).

Wednesday, April 23. 9 a.m. to 12 m.—Midwifery (in the Senate House).

Thursday, April 24.—Surgical Operations at 9 a.m. and 2 p.m. in the Anatomical Schools.

Friday, April 25. 9 a.m. and 2 p.m.—Oral Examination in Surgery (in the Masonic Hall).

Saturday, April 26. 9 a.m. and 2 p.m.—Oral Examination in Surgery (in the Masonic Hall).

" 10 a.m. and 3 p.m. — Clinical Examination. Surgical Anatomy, and Application of Surgical Apparatus (at the Hospital).

" 9 a.m. and 2 p.m.—Oral Examination in Midwifery (in the Masonic Hall).

Monday, April 28. 9 a.m.—Oral Examination in Midwifery. Surgical Anatomy, and Application of Surgical Apparatus (in the Hospital).

PART II.

Tuesday, April 22. 2 to 5 p.m.—Principles and Practice of Physic I. (in the Senate House).

Wednesday, April 23. 2 to 5 p.m.—General and Special Pathology (in the Senate House).

Thursday, April 24. 9 a.m. to 12 m.—Principles and Practice of Physic II. (in the Senate House).

" 3.30 to 6 p.m. — Elements of Hygiene and Medical Jurisprudence (in the Senate House).

Friday, April 25. 9 a.m. to 12 m.—Pharmacology and Therapeutics.

Tuesday, April 29. 10 a.m.—Clinical Examination (at the Hospital).

" 2.30 p.m.—Microscopical Specimens, and Oral Examination (in the Pathological Laboratory).

Wednesday, April 30. 10 a.m.—Clinical Examination (at the Hospital).

" 2.30 p.m.—Prescriptions, and Oral Examination (in the Pathological Laboratory).

Thursday, May 1. 10 a.m.—Clinical Examination (at the Hospital).

" 2.30 p.m.—Oral Examination (in the Pathological Laboratory).

EXAMINATION FOR DEGREE OF M.C.

Thursday, April 24. 9 a.m. to 12 m.—Pathology, and Principles and Practice of Surgery (in the Senate House).

" 2 to 4 p.m.—Essay on Surgical case and Topic relating to Surgery (in the Senate House).

Friday, April 25. 9 a.m.—Oral Examination and Surgical Operations.

Saturday, April 26. 11 a.m.—Surgical Anatomy and Clinical and Oral Examination (at the Hospital).

Any student who has passed both parts of the Second Examination may be admitted to the Second Part of the Third Examination as a candidate in *Pharmacology and General Pathology only*, provided that he produces the Certificates mentioned in the first paragraph of the new Regulation 20 (*Ordinances*, p. 182), and pays to the Registrary a fee of £3 3s. for the University Chest.

The names of candidates for these Examinations must be sent to the Registrary on or before Saturday, April 12. Candidates who are members of the Senate may send their names to the Registrary direct. All other names must be sent through the Prælectors of the respective Colleges.

Forms on which it is requested that the names may be written will be sent to the Prælectors.

The certificates of candidates, accompanied by their postal addresses, must be sent to the Registrary on or before Wednesday, April 16.

The fees for each Examination must be paid to the Registrary when the certificates are sent in. *The fee is £3 3s. for each part of the Third Examination;* but for candidates who passed both parts of the Second Examination before 1st January, 1900, it is £2 2s.

The fee for the Examination for the degree of M.C. is £3 3s.

Any candidate whose name and certificates have not been sent in and fee paid at the proper time is liable to pay an additional fee of £1 if he be nevertheless admitted to the Examination.

Registry, March 3, 1902.

Sport.

Rugby Football.

GUY'S v. ST. MARY'S.

Inter-Hospital Cup-Tie. Final Round.

Losing the toss, Mary's kicked off against the wind. A good return by O'Brien brought play to the half-way flag, and after a good deal of forward work in which Guy's were superior, some indifferent passing by our three-quarters took the ball into Mary's twenty-five. Here several scrums took place, but Mary's forwards were getting the ball well and were breaking up quickly so that our backs had few good opportunities, and we were forced back to half-way. By a good kick, however, by McEvedy, Guy's again reached Mary's twenty-five, but after a couple of poor attempts at passing among our three-quarters, Mary's again brought play to half-way. Then, after some give and take play, we were awarded a free kick, and Mary's were compelled to touch down. Immediately after the drop-out we were awarded another free kick, and our forwards followed up well and collared the full back, but an excellent chance of scoring was missed, and the ball was again taken back to half-way. An excellent kick by Alcock sent the ball into touch two yards from the corner flag, but again erratic passing by our backs prevented a score, and after some rambling play the ball was kicked across the goal-line and Mary's kicked dead. A little later Alcock following up a kick collared the full-back, and although there were several of our men there unopposed, a bad pass again spoiled a good chance of scoring. Guy's continued to press for some time, but the efforts to score were fruitless. Once McEvedy broke through the opposing backs and passed to Morgan, but although the latter crossed the line he lost the ball and a touch-down resulted. Then O'Brien dribbled to the full back, but the game was stopped owing to an injury to a Mary's man. In the next scrum Mary's got the ball, but Wetherell came round smartly, and dribbling brilliantly up the field, eventually picked up and passed to Lawry, who ran over and scored. The try, however, was disallowed, apparently because the referee considered the pass forward. Shortly after this O'Brien gathered the ball smartly and set Morgan going, who, after a brilliant run, scored and kicked the goal, a few minutes later in some good loose forward work, Thompson picked up and scored. Morgan's kick just went outside the post. Then Mary's began to attack, and by good loose rushes, for the first time during the game reached our twenty-five, the ball going into touch a few yards from our goal line. Relief was, however, immediately brought by a free kick, and the half-time was called with the score, Guy's 8 points, Mary's nil.

Thomas kicked off, and after an interchange of kicks, play settled down in mid-field, until Thomas headed a rush to the twenty-five. Then from a scrum Payne came through in great style, and passed to Thomas, who, however, was held up when over the line. Immediately from a scrum some passing among the whole of our backs resulted in Morgan scoring, but his kick at goal again just missed the post. Then from a scrum in the centre of the field the ball came out to O'Brien, who drew his men well and passed to Morgan. The latter smartly dodged the full-back and scored, but his place kick failed. Then several good runs were made by our backs, and at length McEvedy, when tackled on the line, passed to Glendinning, who scored. O'Brien took the kick, but failed. From this time Mary's had much more of the game than before, and repeatedly carried the game into our half of the field, although they were playing one short, their full-back being injured. About this time, however, Payne injured his knee and was carried off, and a little later McEvedy was hurt and retired. The game now became rather wild, first one side and then the other racing up the field. Several times Mary's got within a yard or two of our goal line, and on one occasion Harrison was left with two men to stop. He very luckily intercepted the pass, and ran up the field. Then several of our men endeavoured to fall on the ball and score, but none succeeded, and a touch down resulted. Shortly afterwards no-time was called, Guy's thus winning by 1 goal 4 tries (17 points) to nil. Team:—

Guy's.—E. M. Harrison (back); F. Alcock, P. F. McEvedy, A. O'Brien, E. Morgan (three-quarter backs); O. V. Payne, M. C. Wetherell (half-backs); H. A. Cutler, R. C. Lawry, T. P. Thomas, R. G. Anderson, E. L. Ward, B. Glendinning, A. R. Thompson, E. H. B. Milsom (forwards).

Association Football.

GUY'S v. ST. MARY'S.

Final Tie.

This match was played on Monday, 24th, at Upton, in windy, rainy weather. At the start, play was fast and fairly even, our forwards being several times dangerous, but rather less than a quarter of an hour from the start, Denning was heavily charged and had to leave the field, his collar bone being broken. Within a few minutes, Norton scored our only goal after a good run, and Mary's equalised soon after. The remainder of the first half was fairly even, Mary's, however, scoring once more. The teams changed ends with Mary's leading by two goals to one.

Soon after the re-start, Pedrick went lame from a kick, and our team were severely handicapped. Although we managed to get the ball up the field, our forwards were too well marked to score, and playing with only nine men, our defence was quite demoralised as a whole,

although the individual players were in great form, and Mary's scored three goals in quick succession. The remaining stages of the game were rather tame, though both sides played with plenty of dash till the finish.

Edey, Wilson and Frankenberg worked wonderfully hard, and at one time looked as if they might save us the game. But the Mary's team were the best team we have met in Cup ties this season, and it was most disappointing to lose our best half-back in the first half before either side had scored, and to lose another half after changing ends. Many opinions have been expressed with regard to the result if our team had sustained no injuries. We will only say here that our opponents are too good a team to play when we are at a disadvantage. Team :—

Guy's.—E. A. Collins (goal); T. Edey, A. R. Wilson (backs); P. Pedrick, A. F. Denning, L. H. Frankenberg (half-backs); C. Wragg, P. C. Litchfield, H. Barber (capt.), E. L. Norton, P. A. Peall (forwards).

GUY'S 2nd XI. v. LONDON 2nd XI.

Junior Inter-Hospital Cup. Final Round.

This match was played at Leytonstone on March 19th, and resulted in a win for Guy's by 3 goals to one. Having lost the toss, we were obliged to kick off against the wind. The ball was light and playful, and the ground was hard, and interesting by reason of its eccentricities. This may have accounted for the poor quality of the play, but there was no excuse for the slackness shown during the course of the game. For the first twenty minutes the game presented no points of interest beyond the number of fouls given against London. At length, however, roused by a narrow escape, due to a mistake made by Leeming, the forwards got away, and after some weak work in front of goal, succeeded in scoring through Chignell. After this the men simply went to pieces, the forwards were feeble, the halves slack, and of the backs Crofts was the only one of any use, Leeming missing almost every kick. In spite of this, however, London did not succeed in scoring till close upon half-time.

In the second half, the game was more like a cup-tie, but the forwards were dismally weak in front of goal. Harland, who played a good game on the right wing, centred well, and from one of these Wilson scored from a mistake on the part of the goal-keeper. Several dangerous rushes were made by our opponents' left wing, but Zorab at right half ruthlessly nipped them in the bud. After one or two abortive rushes on the left, Chignell got the ball in front of goal, and put on a third point. Soon after this Foster was hurt in a rush and had to leave, but we were able to keep them from scoring until the whistle went while the ball was being fished out of a back garden in lateral relation to the ground. Team :—

Guy's.—Turner (goal); Crofts and Leeming (backs); Cole, Foster and Zorab (halves); Messent, Wilson, Chignell, Barlow and Harland (forwards).

Appointments.

CIVIL.

Brodrick, C. C., L.R.C.P., L.R.C.S., L.M. Edin., has been appointed Medical Officer and Public Vaccinator for the Whitchurch District of Tavistock (Devon) Union for three years.

Green, Albert, M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Coroner for the Hundred of Scarsdale, N.E. Derbyshire, *vice* C. G. Busby, resigned, appointment to date from March 14th, 1902.

Lambert, F. E., has been elected Honorary Dental Surgeon to the Brighton, Hove and Preston Dispensary.

Meachen, Norman G., M.B., B.S. Lond., M.R.C.P. Edin., has been appointed Honorary Dermatologist to the Tottenham Hospital, N.

NAVAL AND MILITARY.

Surgeon-Captain H. Williams, South Nottinghamshire Imperial Yeomanry, resigns his commission, and receives a new commission, subject to the provisions of the Militia and Yeomanry Act, 1901, retaining his rank and uniform.

Surgeon A. J. Wernet, R.N., has been appointed to the *Pembroke*, additional, for service at Deptford Victualling Yard.

Surgeon-Lieutenant G. H. Daniell, M.B., Dorset (Queen's Own) Imperial Yeomanry, is promoted to be Surgeon-Captain.

Surgeon-Lieutenant J. R. Evans, 1st (Pembrokeshire) Battalion the Welsh Regiment, resigns his commission.

Captain H. D. Eccles, Commanding the Mongonui Mounted Rifles, New Zealand, has been appointed Surgeon-Captain in the 8th Contingent, N.Z.M.R.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Birth.

GILBARD.—On March 13th, at St. Margaret's, Purley, the wife of R. Gilbard, M.R.C.S., L.R.C.P. Lond., of a son.

Death.

MANSON.—On March 8th, at Christmas Island, from a gun accident, Patrick Thurburn Manson, M.B. Lond., aged 24 years, eldest son of Dr. Patrick Manson, C.M.G., F.R.S.

Ed.—D. G. G.

Contents.

	PAGE
A Case of Addison's Disease: Clinical Lecture by Dr. Taylor	145–151
Reform of the Army Medical Service	152–154
Appointments	154
Passim	155–157
Nursing News	158
From the Gazette's Special Pathologist	158
Acute Bright's Disease	158–161
Papers by Guy's Men	161
Types	162
Correspondence: A Literary Society	163–164
Novelties	164
Sport: Guy's Hospital Swimming Club—Annual Meeting	164

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold will be One Shilling and Sixpence.

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Calendar of Coming Events.

April, 1902.

Sat. 12.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. E. Brayne and C. E. Adams; Cl., W. G. Parker.

Mon. 14.—First and Second M.B. Durham Exams. begin.

Thur. 17.—Messrs. Jacobson and Fripp's take-in; Drs., J. Goss and S. H. Ackroyd; Cl., C. Tessier. Last day for sending in Fees and Certificates for Third M.B. Camb.

Fri. 18.—Third and Final M.B. Durham Exams. begin. Examinations for M.D. and M.S. Durham begin.

Tues. 22.—Cambridge Third M.B. Exam. begins.

Thur. 24.—Messrs. Symonds and Steward's take-in; Drs., C. H. Bubb and H. Johnson; Cl., F. L. Thomas.

Guy's Hospital Gazette,

APRIL 12, 1902.

A Case of Addison's Disease.

CLINICAL LECTURE BY DR. TAYLOR.

March 1st, 1902.

Gentlemen,—I am going to speak to you to-day about a case of Addison's disease. As you know, Thomas Addison was a physician to Guy's Hospital, and he it was who discovered the association between the suprarenal glands and those symptoms of which pigmentation of the skin is usually the most prominent. It is interesting to note that the discovery was made by him in the course of researches and observations in the study of the disease which he called idiopathic anæmia, and which is now more often called pernicious anæmia.

The clinical features of the disease are the following:—The patient is affected by three prominent symptoms, namely, pigmentation, abnormal or morbid, of the skin; a considerable degree of physical weakness together with a feebleness of the circulation, that is a weak heart and pulse; and thirdly, gastro-intestinal disturbance, especially nausea and vomiting.

The patient is a well-formed man, 27 years of age. He was admitted for general weakness and pigmentation of the skin. He was well until four months ago when he became languid and drowsy, being unable to continue work. Soon after he was noticed to be growing of a darker complexion. He used to vomit frequently and was seized with attacks of dizziness. Gradually his whole body became darker in colour. In December, 1901, he was on some scaffolding when he became dizzy and fell thirty feet. Since then he has been growing worse and has been totally unable to work. Pigmentation became more marked and of a darker brown colour. He became dizzy on slight exertion and vomited two or three times a week. His appetite was poor, bowels regular; he has lost two stone in weight; he has had no pain.

As part of the family history we hear that his father and grandfather both suffered from attacks of dizziness.

Personal history.—The patient was married when sixteen. He does not smoke and he drinks two pints of beer per diem. He was in St. George's Hospital when six years old, with low fever. He became yellow at the beginning of 1901, but regained his normal colour again. Temperature 95°, pulse 104, respiration 16. He is a sturdy-looking man of dark complexion; his skin is dark all over the body, but the darkening is more marked in some parts than others. His face and hands are more deeply pigmented than any other part of his body. The pigmentation does not extend to the hairy part of the scalp. The conjunctivæ are normal. The mammary areolæ are deeply pigmented, and there is a faint line running up from the pubes to the umbilicus. There are patches on the dorsal surfaces of his feet in places where the boots press. The mucous membranes of the cheek and of the lower lip are pigmented. On the back of the neck are some dark patches. His axillæ, groins, shoulders, and scrotum are not deeply pigmented. There are one or two deeply pigmented moles on the body.

There are a good many persons who are naturally of a dark complexion, but I think you will not have any difficulty in recognising that this pigmentation is abnormal. We have his word for it that he was not so dark before the onset of his present symptoms, and you will see that the coloration of his body is different in different places, and that it is not equally and uniformly dark.

(The patient was here shown to the class, but fainted during the demonstration, and was therefore removed.)

Though you have just seen him by rather imperfect daylight, you will have had a very good impression of the general features of the pigmentation, especially this—that the pigmentation is not in patches, that is to say, there are no patches with sharp margins. On the other hand, in most cases it is not uniformly distributed over the body; but the pigmentation is of greater intensity in certain parts, and this fact is illustrated to some extent in this patient. The exposed parts are often darker than the others. That is true in this case. The face is deeply pigmented, and at the same time the scalp, which is covered by hair, and the upper lip, covered by his moustache, are nearly white; that is, very little pigmented, and probably no more so than in health. I remember a case some time ago where the face was much more darkly pigmented than in this case; and the forehead was deeply pigmented right up to the scalp. In the present case the most marked pigmentation stops about half an inch from the scalp on the forehead, and one inch or so from the part of the scalp where the hair recedes near the temples. I do not know that that is of any importance, but I am pointing that out as a matter of fact—that the deep pigmentation in this case does not reach absolutely to the scalp but has a definite abrupt edge at a short distance from it.

Some other parts are pigmented very deeply, especially the dorsal surface of the fingers. There is a good deal of darkening over the forearms, especially the dorsal or upper surface. The knees are very distinctly pigmented, and there are irregular patches of pigment over the dorsa of the feet which are referred to in the report and attributed to pressure of his boots.

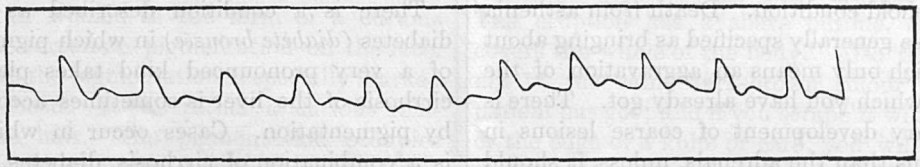
In general, the rules which seem to guide the first appearance or the stronger development of pigmentation in these cases are the following: The exposed parts, the dorsa of the hands, and the face are deeply pigmented. In those parts that are subject to pressure of garments, especially along the line of waist bands in females, or on the legs where garters are worn, there is a liability to have pigment developed. Other parts which are generally pigmented include the nipples, the genitals, the axillæ and other parts where pigment is naturally abundant. For the most part, these facts are represented in this case.

Other points about the pigmentation are these. There is very frequently a pigmentation of the mucous membrane of the mouth or lips, sometimes a line of bluish-brown pigment along the inner surface of the lower lip, and upon the

inner surface of the cheek, on either side. That, again, is the case in this patient.

Then also a good many cases have small specks of pigment in different parts of the body. This patient has some deeply pigmented moles, which, however, might have been there before. But the recent occurrence of small dark pigmented spots upon the body has been frequently noticed in these patients, and it is quite likely that in this patient, as time goes on, some of these spots will be developed.

We come next to another feature of the disease which is characteristic, that is, the physical weakness, the asthenia, or loss of power, that the patients present. You have had a demonstration of that in this case. The patient was at first sitting in the chair. I got him to undress and to come and stand in front of you, an operation taking about five minutes altogether, and he felt so faint that he had to sit down; and then he had complete syncope with some convulsive twitchings of the face. In the history we have other facts illustrating the same thing; first, that he was dizzy and fell from a scaffold; and secondly, that four months ago he became languid and drowsy, being unable to continue work. Again, while in the ward here he was attempting to pull down the blind and he fainted and fell on the floor. This physical, or perhaps rather cardiac weakness, is in his case obviously out of all proportion to his nutritional failure. He is stated to have lost flesh, but he is not emaciated; he is quite as well covered with fat and muscle as numbers of healthy people. We have evidence of this asthenia in another way, that is, in the physical signs of circulatory system. His pulse is feeble, weak, and rather quick. A sphygmographic tracing of the pulse has been taken by my clinical assistant, Mr. Robson, and it shows a pulse of low tension requiring two ounces pressure. And it shows the so-called "respiratory wave," that is, the tracings of the individual beats do not follow in a true horizontal line, but form a series of short curves, each curve corresponding to five or six beats. This is always an indication of considerable feebleness of the heart's beat. Yesterday I obtained with a Marey's sphygmograph a similar tracing, which is here shown:—



Tracing of radial pulse. Pressure two ounces.

In the case before us, the pulse is markedly quick. In most cases you will find the pulse quick and at the same time small. My clinical assistant, Mr. Robson, says that the pulse varies from day to day between 85 and 95. In other recorded cases 90 to 100 are the figures constantly given as the pulse rate.

The question of anæmia is always of interest, especially when one remembers that it was in the study of anæmia that Addison discovered melasma suprarenale. In many cases there is no pronounced anæmia. In the present case the blood count gave 5,033,333 red corpuscles, an amount fully up to the normal. But the hæmoglobin is given at 61 per cent., showing that there is a certain degree of anæmia. The white blood corpuscles number 5,312; they are not in excess, but somewhat under the general average.

With regard to vomiting, or anorexia, or other disturbance of the gastro-intestinal functions, we have it stated that he used to vomit frequently in the early days of his illness. More recently he has vomited two or three times a week. Since he has been under treatment here, about a week, the vomiting has chiefly been induced by the suprarenal tabloids which have been administered to him, and I have no record here of his being sick spontaneously, but I see that he has been sick twice after food. His appetite is poor, but his bowels are regular.

Those are the main features of the disease, and the patients remain in that condition very often for a long time. The course of the disease is this, that the patient gets weaker and ultimately loses flesh, his pulse becomes more feeble, he is more troubled with sickness and nausea, and very often rapid prostration takes place and he dies. Sometimes the patients become delirious and prostrate and terminate their illness quite rapidly. Sometimes the patients get into a more or less typhoid condition. Death from asthenia is the cause generally specified as bringing about death, which only means an aggravation of the condition which you have already got. There is no necessary development of coarse lesions in other organs than the adrenals, unless it should be, in some cases, the development of phthisis, or tubercle of the lungs, or general tuberculosis. That must be not very frequent.

The question of diagnosis, of course, becomes very interesting. There is no difficulty in recognising the present case. The occurrence of these three symptoms—the pigmentation, the asthenia, and the vomiting—is so manifest, all the symptoms came on together in such a pronounced way, and have continued, that the diagnosis so uniformly is absolutely plain and certain. The difficulties in diagnosis arise, of course, in the early stages. The patient has first some discoloration, or some modification of his natural colour, and if that modification is associated with any physical weakness, the question of Addison's disease will naturally arise to the medical man whom he consults. The difficulty then, lies in determining whether the patient has Addison's disease or not. If you were to look over old Reports, you would find it frequently the case that patients have come into the hospital under the suspicion that they were suffering from Addison's disease, and that no definite opinion or agreement has been come to on the part of those who saw the cases, as to whether the patients were really so affected or not.

In many conditions of disease pigmentation is admitted to take place. You get it, for instance, in other cachectic conditions, especially in conditions of tuberculosis and of cancer, and sometimes the pigmentation is distributed in somewhat the same way. The face may darken, and the abdomen frequently darkens.

Jaundice is a condition which sometimes gives rise to a little difficulty; the patient may get a little darker with incipient jaundice, and may have a yellow tint of the conjunctiva, and so a suspicion of Addison's disease may be entertained.

It has been noticed that in some pancreatic diseases there is pigmentation to a slight extent.

There is a condition described as bronzed diabetes *(diabète bronzée)* in which pigmentation of a very pronounced kind takes place; and cirrhosis of the liver is sometimes accompanied by pigmentation. Cases occur in which there is a combination of cirrhosis, diabetes, and pigmentation of the skin. The pigment is said to be derived from the blood, and the name hæmatochromatosis has been accordingly given to the condition. The view has then been entertained that while the pigment is deposited in the skin, it is deposited in the liver so as to cause cirrhosis, and also in the pancreas so as to cause diabetes. The explanation seems simple, but I doubt if the facts recorded are sufficient to justify one in accepting this view without further consideration and observation of other cases.

In relation to that, I may mention a case that died in the ward some three years ago. It was a boy whose case I recorded in the Guy's Hospital Reports* under the voluminous title of Splenomegalic Cirrhosis. That boy had hypertrophic cirrhosis of the liver, with jaundice, and a very large spleen. The duration of his jaundice, from the commencement of it till his death, was between five and six years. There was no information as to whether he had acquired this cirrhosis through drinking alcohol, and we are at present unable to explain its occurrence. This patient was very deeply pigmented. His fingers were very dark, and especially in their distal halves, and on the dorsal surfaces. The pigmentation over the rest of the body was to a certain extent obscured by the darkness of his jaundice, and perhaps it would be difficult to say what share each had in the discoloration. Other cases have been recorded in which

* Guy's Hospital Reports, Vol. liv., p. 1.

jaundice, pigmentation, hepatic cirrhosis, and enlarged spleen were associated. I do not wish to say that there was any reason for his being considered to have Addison's disease; I am only pointing out to you some of the conditions under which pigment occurs, and also the fact that there are some points of resemblance in the distribution of the pigment.

Then you will remember the condition known as chloasma uterinum which is quite common, occurring in women in the form of a curious and very unfortunate pigmentation on the face. There again the pigmentation is specially marked on the forehead. It has rather a curious relation to the hair. The pigmentation occupies frequently the temples rather markedly, and forms sometimes a broad band over the forehead, just keeping as far off from the scalp as the pigmentation in this man. At the same time there are dark rings round the eyes. This discoloration varies a good deal with the uterine conditions. It is aggravated during the menstrual periods, or during the period of pregnancy, or perhaps only appears during the course of pregnancy. There is not much fear of your mistaking that condition.

In malarial conditions you get so-called melanæmia. The pigment is derived from the hæmoglobin of the corpuscles in consequence of the attacks of the plasmodia. The patients have a sallow appearance due in part to that, and in extreme cases pigmentation of the internal viscera takes place. Dr. Bright reported a case in which pigment was found in the membranes of the brain in a malarial patient.

In cases of exophthalmic goître there is a certain amount of pigmentation, and small pigment spots form in the skin in the course of the disease like those seen in Addison's disease.

In chronic rheumatic arthritis you get pigmentation.

Those are conditions in which, so long as you know the fact that pigmentation is associated with them, you will only look at the pigmentation as part of the disease, and not run the risk of confounding them wfth Addison's disease.

There are two other conditions that ought not to be confounded with Addison's disease, as sometimes they have been. One is tinea versicolor, a disease of the skin. A fungus grows in the epidermic scales, and this process is accompanied by a certain amount of darkening of the skin. Mostly it appears on the chest and the abdomen, and if it is very uniformly distributed over the surface it might be mistaken for Addison's disease. It ought not to be. There are many points about it that ought to guard you against any such mistake as that. The eruption has a sharp outline, and never covers the whole of the body. Also the skin is not of the same dark-brown colour that this patient has got; and if you scrape it with a knife, or the edge of a knife or card, you will roughen up the epidermis, the nutrition of which has heen disturbed by the fungous growth; the skin is not smooth. Moreover it affects the body, but not the face; the pigmentation never rises higher than the neck, and if you have a perfectly healthy face and this condition of the skin, the distinction between the two diseases is quite clear.

The same distinction holds with regard to another disease, namely, the so-called vagabonds' disease, or pediculosis; that is, a condition of the skin due to lice infesting the clothes next the skin. In this disease you may get very intense pigmentation; the skin may be quite as dark as any part of that patient's body. The pigmentation is due to the constant irritation of the lice themselves and the scratching that their presence induces. The patient may have a skin almost as brown as mahogany and yet the face will be perfectly clear, because the lice are only present were clothes are and they do not get into the face. Besides that, the deeper the pigmentation, the more evidence in the skin will there be of the lice which have brought it about, namely, scratch marks, blood-scabs, scars, or papules due to the scratching.

In the same way it is conceivable that the disease named prurigo, where you get a condition of itching which is spontaneous and subjective and not induced by pediculi, might bear some resemblance to Addison's disease, but here again you would have all the evidence of the scratching which is not present in the case that we have just seen.

Another possible cause of difficulty is this. We know, especially from the experience of late years, that the frequent use or exhibition of arsenic in medicine, and the accidental contamination of beer by arsenic, of which we have heard so much within the last year or two, may bring about a very pronounced degree of pigmentation in different parts of the body.

With regard to the pigmentation I have missed out a point which has some bearing upon Addison's disease. It is known that any kind of enlargement or disease which presses upon, or interferes with the important nerve structures at the back of the abdomen which are in close proximity to the suprarenal capsules, may bring about pigmentation and may also be associated with some amount of asthenia and vomiting. Cases of Hodgkin's disease in which, you know, the lymphatic glands may be enlarged all over the body, have been known to have pigmentation, when the glands in the back of the abdomen, in the neighbourhood of the solar plexus and semilunar ganglia, have been enlarged and have pressed upon those structures. One can see that there might be a difficulty in determining whether the whole of the trouble was due to such glandular enlargement as you could find evidence of, or whether there was in addition some implication of the suprarenal capsules.

So far we have considered pigmentation as the chief factor in diagnosis; but in cases where pigmentation is slight or absent, the other symptoms, asthenia and vomiting, would be of more importance, and the patient might be anxiously examined with regard to his stomach to see whether there was a cause for the vomiting there, and to make quite sure that he had not got any organic disease in the neighbourhood of, or involving, the stomach.

We now come to the pathology of the disease. What are the structures involved? I have told you that those structures are the suprarenal capsules, and I think every one admits that the most common lesion to be found is tuberculosis of the suprarenal capsules. In a much smaller number of cases there is atrophy of the suprarenal capsules; or a fibroid change causing degeneration of the organ—a cirrhotic atrophy. In some cases there is malignant disease. It is interesting that every case of malignant disease of the suprarenal gland is not accompanied by the symptoms of Addison's disease. There may be cancer of the suprarenal capsules without any symptoms which distinguish Addison's disease. The question is, Why are they present in some cases and not in others? The probable explanation is that in those cases in which the symptoms do not appear, the disease of the glands has not been of sufficiently long standing to seriously interfere with the performance of their physiological functions. Whether that is an adequate explanation must remain doubtful. Occasionally blood extravasations have been found. Occasionally there have occurred cases in which the suprarenal capsules have been found healthy, although there has been some implication of the nerve structures in the immediate neighbourhood. Cases have been recorded where glands, apparently quite healthy, were surrounded by malignant disease, and it is suggested that in those cases the malignant disease has interfered with the vascular connections so as practically to render the glands functionless.

You all know that the modern view that the so-called ductless glands, and even others, such as the kidneys and pancreas, secrete some material, or form some products, which are taken up into the blood, and which are of the greatest importance in the economy. The researches of the last few years have shown such extraordinary connections between these quite small internal organs and the functions of the body generally, that one is bound to admit their powerful influence, and the above appears to be the most reasonable way to explain it. I may remind you of the relation of the thyroid gland to myxœdema, of the pituitary body to acromegaly, and of the ovaries to osteo-malacia, and perhaps we may add, of the pancreas to diabetes.

So, also, in regard to Addison's disease, the view is widely held that the disorder is due to the absence from the blood of some material normally formed in the suprarenal glands, and

this is caused by the destruction of those glands by tubercle, atrophy, or cancer. Before the theory of an internal secretion had made any way, the suggestion was put forward that the disease was due rather to the auto-intoxication or poisoning of the body with some products which the suprarenals ought to have destroyed, as for instance, the pigment. That view, however, is not sufficiently supported, and the theory of an internal secretion at present holds the field.

Then there is the question, Does the value of the internal secretion lie in its preventing auto-intoxication of the body by neutralising something, or does it lie in direct functions which it performs with regard to the body generally? What is well known now, with regard to the suprarenal glands, is that they have a very powerful influence in stimulating muscular action throughout the body. This physical weakness that we notice in this patient, and the cardiac and circulatory weakness which we recognise in him are, so to say, more or less a demonstration of that particular point. It does look as if the material which can be obtained from the suprarenal glands was deficient in those cases where we know the gland to be manifestly diseased.

That leads us up to the last point—treatment. On this subject also there is yet a great deal to be learnt. The recognition or belief that an internal secretion is concerned in this process, I think, leads one to suppose that we may, as we do by administering thyroid gland in myxœdema, get some benefit in Addison's disease by giving suprarenal capsules or extract of the capsules obtained from animals. During the last five or seven years that method has been rather extensively tried. I have been endeavouring to ascertain within the last few days to what point we have got in this study. In some cases it is stated that no good has resulted at all. In some cases patients have died very shortly after the administration of the drug. Too much importance must not be attached to that, because these patients do die suddenly or rapidly without much warning. The sudden collapse of a patient apparently going on well might easily occur as a coincidence a few days after the administration of the extract. There are other cases in which the extract has made the patient vomit, as has happened in this case. There are others in which the capsule given for some weeks or months has apparently increased the physical powers of the patients, and also diminished the pigmentation, and there are other cases in which the patients have improved their bodily power and have not shown any material alteration in the pigmentation. Many of those who have shown some improvement in the ways mentioned have, after a few months, gone more rapidly downhill, just as they would have done without the treatment.

In a published list of forty-eight cases* which Mr. Robson has kindly found for me, six cases are given as cured, twenty-two improved, eighteen unimproved, and two aggravated. If the cures and the improvements were maintained, the results ought to encourage us to persevere with the treatment.

A curious result of the treatment is recorded by Mr. Béclère,† He gave the extract for nearly five months without any result at all and so left it off; the patient then got very much better, though not back to his old health, and went on for some time improving. Three years afterwards he was much better than he had been before. Mr. Béclère suggested that the suprarenal extract did not act like thyroid extract, which immediately supplies something that was wanted which the patient's thyroid gland could not supply, and therefore has to be given month after month and year after year, in order to keep the myxœdema patient in a satisfactory condition; but that it favoured a hypertrophy of parts of the suprarenal gland which were unaffected. That, of course, is only a pure hypothesis, and is not supported by the events recorded in other cases, though it is conceivable that the accessory suprarenal structures which are known to exist, might take on the hypertrophy to which he refers.

* Lancet, 1897.

† Semaine Méd., March, 2nd, 1898: Brit. Med. Jour., Vol. i., 1898, Ep. p. 43.

Reform of the Army Medical Service.

(From an Occasional Correspondent.)

We have before us a copy of the new Royal Warrant for Pay and Promotion of the Medical Service of the Army; and a copy also of the Schedule for future examinations in the same service as sanctioned by the Secretary of State. These two papers enable us to test the progress that has been made in the reform promised on several occasions since the need of it was first prominently brought before the public by the historic letters of Mr. Burdett-Coutts from Bloemfontein, in April, 1900. It will be remembered that a Royal Commission was sent out in August of that year to report on the state of the hospitals in South Africa, and its report was issued in the following January; that, according to its recommendations, a Committee of experts was appointed in May, 1901, to draw up a scheme of reorganization of the whole Army Medical Service, and that this scheme was issued to the press in October. The newly constituted Advisory Board and the new Headquarter Staff of the Service were at work before the end of last year. The Pay Warrant and examination rules now in front of us constitute the first practical proof of the genuineness of the promised reform; and must therefore be examined with the greatest care not only by the officers of the medical service, whose whole prospects depend on it, but also by the general public who pay for this service in order that their national Army and their personal relations in that Army may be assured of the best possible medical, surgical and sanitary protection.

A. Pay.—As with the Army at large, so with the Royal Army Medical Corps, Mr. Brodrick enters into competition in the labour-market with other employers of labour; and finds himself compelled to raise the wages of his employés.

	Old Warrant.	New.
Director-General ...	...£1500 per ann....	£2000
	(Consolidated pay & allowances)	
Surgeon-General	£2 15 0 ...	£3 0 0
	(per diem, pay only)	
Colonel	2 0 0 ...	2 0 0
Lieut.-Col. (specially selected)	1 10 0 ...	1 15 0
Lieut.-Col. (on promotion) ...	1 5 0 ...	1 10 0
Major (after 3 years in the rank)	1 2 6 ...	1 6 0
Major (on promotion)	1 0 0 ...	1 3 6
Captain (after 10 years' service)	0 15 0 ...	1 1 0
Captain (after 7 years' service)	0 13 8 ...	0 17 0
	(after 2 yrs in the rank)	
Captain (on promotion) ...	0 11 0 ...	0 15 6
Lieutenant	0 11 0 ...	0 14 0
Lieutenant (on promotion) ...	0 8 0 ...	0 14 0

This shows a substantial increase in the pay of all ranks up that of Colonel: above this the pay was never complained of, except in the case of the Director-General, whose salary is now raised to the amount from which it was cut down only a few years ago, the same, that is, as his equals at the head of other corps and departments, with the curious exception that he alone is not supposed to require a horse for parade; his salary is therefore £2000, not £2100 like theirs.

To compare these prospects with those of civil medical practice, we take the private statement of an agent who has had twenty years' experience of dealing with the transfer of practices. He says, "I take the average gross income of fifty per cent. of medical men starting general practice to be (*a*) at starting £500; (*b*) after three years £600; (*c*) after ten years £800 to £900; (*d*) after twenty years £900 to £1200 per annum. The professional expenses, including drugs, dispensary, horses, carriages, and stable expenses, may be taken as averaging at the outside one-third of the gross income, reducing the gross earnings to net incomes of £333, £400, £600 and £800 respectively. The capital required to start on the above lines would vary between £750 and £1500. The selling value would increase in the same ratio as the income." We may compare these incomes with those of the Royal Army Medical Corps under the new warrant, including both pay and allowances:—

	In Civil Practice.	In R.A.M.C., 1902.
On starting ...	£333	£329
After 3 years ...	£400	£403
After 10 years ...	£533—600	£476
After 20 years ...	£600—800	£632 to £750 with charge-pay.

These are the average prospects of 50 per cent. of medical men in either case, although the balance is in favour of the Army officer, who is bound, unless incapable or invalided, to reach his £632 on and after three years in the rank of Major, that is, after fifteen years' service or less. Many will, of course, be promoted to the higher ranks and rates of pay; and the chances of becoming Surgeon-General with an income of £1391 are considerable for any officer who works one-half as hard as his brother practitioner in civil life.

But the comparison is markedly affected by the retired pay assured to Army Officers. In civil life a capital outlay of £750 to £1500 is required at outset, retirement forces itself upon the practitioner at about 60 years of age, and all he can rely on is the capitalised value of his practice and his savings. The Army Officer, however, is assured of £1 a day after twenty years' service; and under the new warrant, if qualified but not selected for promotion, he will be allowed to serve on an extra five years as Major, and earn a pension of £1 2s. 6d. a day whether promoted or not. Surgeon-Generals retire on an income of £730 and the Director-General of £1125 per annum.

The balance is again in favour of the Service when we note that a medical officer in charge of a hospital or division of a hospital may increase his income according to the magnitude of his charge by some £45 to £180 per annum, and, holding appointment as specialist or as principal or senior medical officer to half a brigade or larger commands in the field and abroad, by similar or greater amounts.

There is but one drawback to this favourable view of the Army Medical Officer's financial prospects. It is the fact that in India, whereas living is more expensive, and proportionate allowances are made to officers of other corps, the allowances made to medical officers are wholly inadequate, and on arriving in India they find their financial position entirely reversed. We believe that this is at present a subject of negotiation between the War and India Offices, and may reasonably hope that so real a grievance will be removed. But in the meantime the prospect is clouded, for there is no mention of the subject in the new Royal Warrant.

B. Promotion for Distinguished Service.—The first essential for a good service is to pay it well. We have dealt with this question. The second is to secure efficiency in return for good pay; and, to secure efficiency, it is essential that the right men be promoted. Now, promotion in the Army is of three kinds; (a) substantive promotion, by which, for instance, Colonel Baden-Powell was gazetted Major-General after the relief of Mafeking, passing once and for all over the heads of all other colonels; (b) temporary promotion, by which Colonel Smith-Dorrien and many other colonels were appointed major-generals while in command of a brigade in the field, but from which they revert to colonel's rank on cessation of their command unless otherwise promoted; and, finally, (c) brevet promotion, by which, for instance, many a major in South Africa has become a lieutenant-colonel in advance of his contemporaries, taking rank accordingly, but waiting in the new rank until overtaken by his former contemporaries.

Hitherto brevet promotion has never been granted to medical officers; substantive promotion, which in the rest of the Army is only given to the higher ranks, has been available for all commissioned ranks of the R.A.M.C., but gave rise to so much friction that it has seldom been granted. Now, however, in the new warrant the R.A.M.C. is rightly put on the same footing as the rest of the Army. Substantive promotion, except by examination, with which we deal below, is limited to the senior ranks, and brevet promotion is introduced. Several medical officers, for instance, who have received substantive promotion for their distinguished service in South Africa would in future receive brevet rank instead; and it is expressly stated that distinction in research is to be considered as qualifying officers for this reward—a unique experiment in the British Army. It is to be hoped that brevet promotion will be frequently granted. There can be no better way of securing efficiency of the right kind in the higher ranks of the medical service.

C. Promotion by Examination.—But in order to encourage professional merit of the kind that may be tested by a proper examination, power is given for officers to accelerate their promotion by three, six, twelve, or eighteen months in the examination, which was established by the Camperdown Select Committee in 1889 as the only avenue to the rank of Major. This brings us to another controversial subject. Examinations, it is admitted, are the best test yet devised for comparing the qualities of a large body of men, scattered singly and in twos and threes over the face of the earth, and so it was proposed that at intervals in their career these wanderers should be collected, given opportunities for six months' instruction, and at the end of that time examined for promotion. But bookwork and practical work are two different pursuits, and the old examinations of the Corps laid stress on the former. The new regulations are of the greatest importance, for they throw all book-work to the winds, even in the entrance examination, and in future the only written work is to be of the nature of a report and commentary on cases, in which the facts are given; the examinations, in fact, are chiefly tests of powers of observation and judgment. They will constitute an entirely new departure in medical examinations, and, if successful, will exercise considerable influence on the medical profession in general as well as on the Army Medical Corps.

It is noteworthy that the new examination, proposed by Mr. Brodrick's Committee to admit subalterns to the rank of Captain, has not been adopted; and the hard-working officer will therefore have only one chance, instead of the two originally proposed, of advancing his position by examination. This is a drawback in endeavouring to recruit amongst the first class of medical students, who should be encouraged to enter by knowing that they can by virtue of their own merit overtake their juniors in age and inferiors in ability who have entered the service before them. On the other hand, the addition of this extra examination was likely to scare away all but the most able men with a special faculty for examinations; and we are glad therefore to see that Mr. Brodrick and his Committee have revised their opinion on the subject. It was said, at the time when they issued their report, that they were making of the R.A.M.C. a Mandarin Corps. But as a fact they and the newly-constituted Advisory Board have simplified existing examinations, abolished unnecessary subjects, emphasized the practical and clinical side of the work, and have only added one elementary examination, by which officers desiring promotion to ranks above that of major shall show that they have a 40 per cent. knowledge of medico-military administrative work. This is unlikely to be any serious grievance to them. It should be a great safe-guard of efficiency in the commanding officers of the Corps. This latter object is further advanced by a clause allowing substantive promotion for distinguished service to the higher ranks of the Corps, even where there is no vacancy in those ranks and the new colonel or surgeon-general must for a time remain supernumerary.

D. Other Changes in the Junior Ranks.—Three valuable innovations are now made in the early career of the medical officer. In the first place he may be seconded, immediately on entering the Corps, to undertake or complete the invaluable training afforded by the post of house-physician or house-surgeon in a civil hospital, counting time thus spent towards promotion, increase of pay and pension. In the second place his

service will date from the day of passing into the service, and not from the end of his period on probation. In the third place he may apply to be placed on the Reserve after three years' service, or may retire after eight and a half years' service with a gratuity of £1000. This is a direct bid for the house-surgeon and for the Oxford or Cambridge man, who has hitherto seldom been attracted into the Royal Army Medical Corps.

E. The Reserve.—We note a few other points of change. A reserve of officers useful for active service is for the first time created by allowing men to retire to the Reserve after three years on the active list. This may be of use in attracting men of high calibre, who would refuse to pledge themselves to the Army for life. But it is improbable that the gratuity will be applied for. The free and easy life of the Army proves most attractive to young medical officers; the sound of the drum appeals to all young men of spirit; and distance lends terror, not enchantment, to the drudgery of private practice. It is not until they have seen ten years' service that most Army Medical Officers begin to be attracted to civil life again; and under the proposed scheme they will have had the chance of training themselves as specialists; so that they can retire to work as oculists or Medical Officers of Health with a gratuity or pension secured to them. This new Reserve will probably therefore hardly be called into existence. But this is of no matter. The present war has shown that the true Medical Reserve of the Army is the civil profession; and no other is required.

F. Minor Changes.—We note furthermore that a stingy clause, about no expense being incurred by officers studying when at home on leave, has been cancelled. We note that the channels of intercourse between the R.A.M.C. and the medical officers of the Household Troops who hitherto have been, as it were, in a backwater, are opened out; for whereas in the past a Surgeon-Major in the Guards has had little more to look forward to, he may now, for distinguished service in the field, be promoted to a colonelcy in the R.A.M.C., bringing with it larger prospects and the opportunity of higher appointments. Last, but not least, the Director-General of the Service is, in future, to rank as Lieutenant-General, and this, together with his position on the Army Board and War Office Council and his increased salary, give him, as the head of his Corps, the position obviously due to the head of one of the chief and essential, though non-combatant branches of the Army. We may hope that this innovation will be sufficient indirectly to settle several of the unedifying but often perfectly just "grievances" of the Corps that have been aired all too freely in the public press.

There is one further bit of evidence as to the new Army Medical authorities having started work in earnest, namely that, in pursuance of their intention to found a Medical Staff College in London and give constant facilities for study to officers throughout their career, we understand that negotiations are practically complete for the lease of a building for the purpose and that it will be occupied before the end of the current year. This will supply resident quarters for officers under instruction, and laboratories and the other accessories necessary for the course have been similarly acquired.

Conclusion.—To sum up, therefore, it appears that the better class of medical student, who combines social, athletic and professional ability, will be seriously tempted by Mr. Brodrick's offer, and may, if skilfully managed, join the service in considerable numbers. If thus reinforced, the tone and public spirit of the Corps will at once rise to a level worthy of its work; it will thereby win a position of equality in the Army in general, which at present it has not; and the character and reputation for efficiency of such a Corps, if once established, will in turn continue to attract the best men for the work. For a long time past, the Army Medical Service has suffered from there having been no competition for commissions. Here there is a prospect of competition. But it must not be forgotten that Lord Herbert of Lea's Royal Commission in 1858, recommended the granting of study-leave, and that, although officially adopted as a principle, it has practically never been granted to the present day; that Lord Camperdown's Committee in 1889 recommended a grant of three months' study-leave every seven years, a rectification of the Indian allowances and a shortening of the term of foreign service; and that there are innumerable other instances where the good intentions of a scheme or even of a Royal Warrant have been entirely set aside by the executive. For these reforms to be effective, the public must see to it that the new Advisory Board maintains its functions, and that its recommendations are properly considered by the supreme authority; that the Indian liabilities are properly and promptly met; that the principles involved in promotion by brevet-rank, by acceleration according to examination and by selection for the higher ranks are carried consistently into practice: that specialism and study are made an intrinsic part of the system, instead of, as hitherto, an impious aspiration on the part of meddlesome reformers; and that, if necessary, the numbers of the Corps are raised from 960 to 1,200, 1,500 or any further requisite strength. At present we can but say that Mr. Brodrick has initiated reform where it was needed, and the first-fruits of the reformed system are good.

Appointments.

CIVIL.

Harnett, Charles J., M.D. Lond., M.R.C.S., L.R.C.P., has been appointed Honorary Assistant Visiting Surgeon to the Royal Sea Bathing Hospital, Margate.

Wohlmann, Arthur S., M.D., B.S. Lond., has been appointed Official Balneologist to the Government of New Zealand.

NAVAL.

Staff-Surgeon J. Douglas Hughes, R.N., has been appointed to the *Cruiser*, and Surgeon F. D. Lumley, R.N., to the *Amphitrite*.

Passim.

Of the many brilliant functions that will mark the London season of the present year, the performance at Her Majesty's Theatre will be one of the most interesting to those connected with the Hospital. Mr. Tree, always one of the first to come forward to help charities, has offered the use of the Theatre in the height of the season. We believe that an evening benefit is almost unique in theatrical annals, and of course it is of much greater value than a matinee and we are correspondingly grateful. From rumours that reach us it should be a memorable performance. A series of tableaux representing coronations at different periods will provide gorgeous spectacles, for, as has hitherto been the case, Her Majesty's Theatre will never belie its regal title by anything but the most magnificent designs and superb execution of the spectacular element. Though further details are not at present definitely decided, we hear great tales of the treat in store for those fortunate enough to be present.

We are glad to see that Mr. Ormond's proposal to form a Literary Society for Guy's has not fallen upon barren ground, but has awakened both interest and curiosity, as evidenced by the letters which we publish upon the subject. We may, however, point out, in reply to "J. M.", that his gloomy forecast of the lifeless and insipid course of the contemplated society, and its speedy and ignominous collapse, is entirely without warrant, seeing that what he imagines will be aimed at is not part of the proposal at all. It is not intended that there should be an overstrained effort at erudition or the elaborate mastery of certain schools of literature, nor is it suggested that members should pose as scholarly professors, giving learned and critical disquisitions upon this or that great writer's works; thus taxing both themselves and those who take part in the subsequent discussions. This is not the idea that it is thought to carry out. It is rather, that books and topics of more living interest—that are nearer to us and more within our actual everyday reading—that can be studied and thought about with comparative ease shall be dealt with. To make the society mainly academical in its purpose would certainly be, as "J. M." thinks, a mistake, and would cause it to run great risk, both of dulness and final failure. But if a number of men were associated for the interchange of ideas and convictions upon some of the literary productions that are continually being sent forth, this would meet a great need amongst us, and conduce to our mutual pleasure.

The letter which "F. B." has forwarded marks out a plan which may well form a basis upon which the Literary Society might be formed with this modification, however, that there will be no need to make the severe effort at hard and exhausting study which he seems to suggest. It is not proposed that it should be an educational society, but one for the expression and ventilation of such ideas and knowledge as men have already acquired.

A want has long been felt in the Dental School that there was not sufficient clinical teaching on certain subjects, apart from the everyday practical work. And as a means to this end, a series of clinical lectures has now been instituted corresponding very much in object to that given on the general side, namely, that the *many*, instead of the *few*, as hitherto, may benefit by hearing about actual cases of unusual interest, or clinical matter that each individual teacher may have at his command at the time. In this way it will be seen that this series is in no way intended to supplement the present course of dental surgery lectures, which is excellent in every way. As at present arranged they are given in turn by each of the morning Staff and the two senior Demonstrators, eight during the summer and eight during the winter, the time and subjects being posted at the beginning of each session. So far the attendances have shown that the additional course of lectures is anything but a burden upon the student.

During last summer vacation the central projection in the Conservation Room, which was awkward, both for work and to the eye, was removed entirely, and the whole of the back wall

made quite flush. High and low racks were also erected along the back wall for cabinets and engines respectively, and both of these alterations have proved of marked benefit in considerably relieving the general congestion of the room. At the same time the washing arrangements were made much more convenient. The electric light installation was made complete, and the lamps and the current are now the only necessary adjuncts. Improvements are being made also as fast as circumstances will permit with the Dental Museum. This, until the whole museum block is changed is to occupy the floor of the Surgical Museum. Already the tables down the centre have been removed, and one of the new upright cases is in position and is being fitted up. This is the first of some three or four cases which will contain the dental teaching museum. Yet one other improvement which is imminent. In the immediate future the Conservation Room Student Demonstrators are to be relieved of the arduous and useless duties of distributing tickets to the Dressers and collecting the money from the patients for filling. These are about to be performed wholly by a paid clerk.

Guy's men will be pleased to see that Dr. Arthur Wohlmann has been appointed by the New Zealand Government to advise them in the development of hot mineral springs, which they propose putting to therapeutic uses. They contemplate the use of hot sulphur baths, mud baths and carbonic acid baths on the European method. We understand that before sailing on May 29th, Dr. Wohlmann will make a tour of inspection to all the spas of Europe.

It is not generally known that during the past fortnight Dr. Washbourn has been suffering from influenza complicated by pleuritic effusion. We are glad to be able to say that he is now progressing favourably, and we hope it will not be long before he is again amongst us.

It is always refreshing to learn how things are managed in other hospitals. The article on the work done in the Johns Hopkins Hospital, which Dr. Anderson has written in the Magazine of the Royal Free, gives a very clear and thorough account of the methods employed in America. Their strong side seems to be clinical microscopy; in fact, before entering the wards the Students go through a three months' study of the blood alone, in order that they may be of real use when they get there. Every new patient in the medical wards has blood films prepared and examined within twenty-four hours of his admission, and in cases of typhoid, a count is made every day.

In cases of appendicitis, in which the decision between operation and delay hangs on the balance, a blood count decides the question. The tuberculin test is extensively used, both in the surgical and medical wards. Apparently, the average American mother is blessed with more than ordinary common sense, for even amongst out-patients, medicines are dispensed in the undiluted strength, and the mother will measure so many drops of liq. strych. out of a small bottle by means of a pipette. Many coroners would be wanted in the Borough if we used this method. There is one point on which we may congratulate ourselves on having the advantage. They have no house appointments, as we understand the term, the care of the cases being in the hands of the Resident Physician or Surgeon, who is a man of the standing of one of our Assistant Surgeons; this must mean that the average man is greatly handicapped in gaining a sound knowledge of treatment. Indeed, the highest reward given to the American Student is the post, called *Interne*, the work corresponding to that of our clinical assistants in the medical wards.

The last week in March will long be remembered by the Residents for its whirl of gaiety. Fresh from a generous hospitality extended by them to the triumphant Rugby Fifteen, they turned with unabated zeal to the congenial task of entertaining Mr. Dunn, who to their great sorrow has finally and definitely moved up West. This task was hardly over when the "going-off" night, falling on Bank Holiday, claimed their attention, and they easily passed most previous records by entertaining some

thirty-four guests, making a total of forty-seven to dinner, and the farewells of such popular and able men as Messrs. Gibson, Parrott, Glenn, Forsyth and Thomas, were duly and formally observed. Seldom has such a happy, united and contented band reigned at the end of the Dining Hall, and the loss seems more than usually deplorable.

Messrs. J. A. B. Hammond and M. A. Collins were elected to fill the President's and Vice-President's chairs, in succession to Messrs. T. G. Gibson and H. McD. Parrott. They have our heartiest congratulations.

An alteration in the working of the Dispensary is in the air. It appears to have been noticed that it is undesirable that one man should sit in seclusion in Out-Patients till eleven at night in gloomy, but sordid isolation, and the present idea is, unless we are misinformed, to increase the stock of medicines at the Front Surgery and elsewhere so as to avoid the necessity of keeping the Dispensary open. It would probably occasion great surprise if the authorities were to ascertain the number of medicines required after six p.m., when the genuine labourer (male and female, especially the latter) snatches time from his hours of ease to visit the surgery and bring up his or her afflicted family, and we hope, to quote a half-penny paper, the "life-saving draught" may never fail from the new rule, but we are inclined to think the surgery drugs will have to be at least doubled in number and more than doubled in quantity.

The minor difficulties are, that bottles are usually obtainable at a penny in the Dispensary, and would have to be stocked in the front, or else we foresee the Borough Jury creating fresh scandals if medicines are refused for want of bottles, and we do not envy the task of dispensing. If, however, the principle were extended to the supply of medicines somewhere where they could be reached and compounded, or at any rate, the clinicals were equipped with a handy selection of drugs, the practical value would be a great gain in what is often a very theoretical part of medicine to most men—till they start to do work outside.

There is another more interesting point of view. If the patient gets the medicine for nothing, great will be the rejoicing and the subsequent crush probably larger. If the usual threepence is exacted, the similarity to the much quoted doctor (advice and medicine threepence) will be accentuated, a point that we may be sure will not escape the public, and certainly the dignity of the front surgery officials is endangered, or may be. However, carping exception can be taken to any scheme of reform however elaborated.

In a recent edition of the *St. James's Gazette* a candid if unfriendly critic pointed out the great amount of time spent in waiting at Out-patients and asks pertinently if it could not be avoided. Criticism is good for customs, if unpleasant, and it leads one to the reflection that to get the opinion of the Out-patient authorities means practically the entire use (we do not like to write loss) of a whole day. To begin with, the early bird probably is first seen in the Front Surgery about 10 to 10.30 and given a card to the special Out-patient Department. There he must be before 12 (officially 11.30), and he will be seen about 1 to 1.30, and some will not be seen till 4 or 5, and we have known Out-patients still continuing as late as 7 or 8, though usually in the latter case the patients have only been there since 2.30, as they are former patients. Small wonder if the wage-earner comes to the Front Surgery after working-hours. Is it advisable or practicable to remedy this?

The rumours of peace add point to an appeal, or rather, a reminder, which is being circulated among past Students with reference to the South African Memorial to those who died during their service abroad, and it is hoped that those who wish to share in the commemoration will send their views as to its nature, and a donation as soon as possible. The list is long, and, to many still here, a very sad one; but it will, at least, record the fact that the services of Guy's men and Nurses throughout the war has been worthy of all honour and emulation.

Nursing News.

Matron's Office.

The following Nurses and Probationers have been successful in passing the Examination in Materia Medica and Pharmacy, held on March 19th, 1902:—A. Allen, Anderson, Bell, Broome, Cantwell, Carter, Chittock, Clarke, Collie, Cook, Cooper, Crowe, Dann, M. Davis, Dickson, Dingwall, Dixon, Earp, Essex, G. Field, Gill, Guthrie, Gyles, Hawes, Hecks, Hooper, Horsepool, Hutchinson, Iszard, Jenkins, Macaulay, Maddison, Manning, Millidge, Milman, Norman, Pallet, Perriam, Pettit, Purse, Riley, E. Ripley, A. Rogers, Russell, Savage, Sheldon, Studdert, Thorpe, A. Topping, E. Topping, Walker, Ward, Watson, Webb, Wheatley, Wilkinson, Windemer, Wise, Witchell, A. Wood, L. Wood.

Nurse Copley, Head Nurse in Dorcas, left the Hospital on completion of her three years' training on March 18th, 1902. Probationer Earp has been appointed to succeed her as Head Nurse in Dorcas.

Miss E. Ramsay, who completed her training in June, 1901, has been appointed Sister at St. Mary's Infirmary, Islington. Since leaving Guy's, Miss Ramsay has held the appointment of Night Superintendent at the General Hospital, Tunbridge Wells.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

X.Y.Z., Hastings.—Numerous micro-organisms were seen in this sputum, which contained only a little pus, but the tubercle bacillus was not detected in specially prepared films.

J.D.C., Chingford.—Preparations from the blood serum culture showed pyogenic cocci, and Klebs-Löffler bacilli were present in fair numbers. (Specimen marked A. (M.F.)

J.D.C., Chingford.—The Klebs-Löffler bacillus was not found on the blood serum culture. B. (G.R.)

PATHOLOGIST.

Acute Bright's Disease.

A paper read before the Physical Society by Mr. G. G. Davidson, B.A.

(Continued.)

There are several points in connection with this case on which I should like to have the opinion of the Society. In the first place, what was the probable cause of this man's peritonitis and empyema? Were they solely a part of his nephritis, owning the same cause, and merely an indication of poisoned and deteriorated blood? Or were they more probably the result of some fresh invasion by a new specific organism—the grafting of a new disease on the sodden tissues of an exhausted patient? I incline personally to the second view, and I think they constituted in reality a new disease. You will naturally ask, what specific organism in particular I suppose to have arrived upon the scene, and I venture, in reply, to suggest the tubercle bacillus.

The reason why I do not think the nephritis was the cause of these inflammations is, that the patient had been, for ten days, obviously recovering from his renal symptoms before the peritonitis began; the œdema was subsiding, the urine was increasing in quantity and was ceasing to be albuminous. All these signs of improvement existed in a marked and unmistakable degree when the peritonitis began, and they continued after the peritonitis had occurred. There was no recurrence of renal symptoms. So much for the peritonitis. It was not until a fortnight later still, when the œdema had all but gone, and the urine had long been entirely free from albumen, that a fresh access of fever announced the onset of an empyema. There was no recurrence of renal symptoms when the empyema occurred.

I have suggested tubercle as the cause of the inflammations. The peritonitis left behind it, as I mentioned, a fairly large tumour in the hypogastrium, so that it was evidently pretty extensive. It must have been pretty extensive since four pints of fluid were withdrawn from the abdomen. Seeing that the patient recovered from this extensive peritonitis, the cause of it is not likely to have been the bacillus coli communis. It must have been an organism of milder manners, if it were an organism at all. You will remember that in the previous history of the patient I mentioned an abscess of the thigh, which followed a kick, and which healed up but broke out again spontaneously after an interval of five years. This looks like a tubercular focus, and if so, nothing is more likely than that tubercle should be lighted up again, when the patient had been thoroughly exhausted by seven or eight weeks of illness. But however that may be it is not necessary that there should have been a tubercular focus of older date than the nephritis.

It would probably not be difficult to collect from post-mortem records a few cases in which acute Bright's disease was actually complicated beyond a doubt by

tubercular peritonitis, or tubercular pleurisy, or both. On looking through the medical reports of 102 cases of acute Bright's disease of all degrees of severity, I came across one such case. The patient was a woman of thirty-six, who was admitted under the care of Dr. Pye-Smith on January 15th, and died on February 8th, 1897. She had been ill for four weeks before admission with swelling of the legs and abdomen; there had been a diminution in the amount of urine, and the urine had been, as she described it, "thick." She had as a matter of fact albuminuric urine—the albumin amounting to 5 per cent., and there were red and white corpuscles and casts. In some points her case resembled clinically the case of the man which I have described, but it was much more severe. As in his case, so in hers, the tension of the pulse was low, there were no cardio-vascular symptoms and no retinal changes. He had passed little urine, this patient passed hardly any. In the first case there was severe diarrhœa, and so there was in this case, but it was almost twice as bad. There is one striking point of difference between the two cases, but it has a definite explanation. In the case of the man, after paracentesis abdominis had been once performed, the fluid did not collect again in the abdomen. In this woman's case paracentesis was performed five days after admission when 9 pints of fluid were withdrawn. The fluid rapidly re-collected, and ten days later 9½ pints were withdrawn. The extreme degree of ascites, together with some indications of an alcoholic history, inclined Dr. Pye-Smith to the belief that she has cirrhosis of the liver, as well as acute nephritis, and this conjecture was confirmed at the autopsy. The fluid withdrawn at the first paracentesis is described as "semi-translucent and greenish." I don't know what this means, but possibly the writer meant to indicate that it was not clear serum. The patient was slightly jaundiced for a fortnight before her death, and this was found at the autopsy to be due to gall-stones, one of which obstructed the common duct. She was delirious a few days before she died.

Besides the excessive and recurring ascites there are two other points in which this woman's case differs from the case of the man. She had no pyrexia, and she did not complain of pain. Seeing that she was delirious, the second point is not much to be wondered at. It was not suspected before the autopsy that she had either peritonitis or pleurisy, but she had both. The kidneys were large, weighing eighteen ounces. They were mottled, and the capsules stripped off easily. They are described as showing acute tubal and interstitial nephritis, but no microscopical examination was made.

There was lymph over the base of the lower lobe of the right lung, and a calcareous nodule on the corresponding surface of the diaphragm. There were scattered tubercles over both pleuræ, more numerous on the right than on the left, and there was a good deal more fluid (℥31) in the right cavity than in the left (℥x). There were miliary tubercles, said to be clearly of pleural origin, in both lungs. The apices of the lungs were unaffected, and the bronchial glands were normal. The diaphragm was covered on both surfaces with tubercle. "I was inclined to think," says the post-mortem demonstrator (who has not signed his name on the report), "that the tubercles on the under surface were a little older than those on the upper, but I am not sure. It is clear," he goes on, "that the tuberculous disease was a local affair, starting either in pleura or peritoneum, not affecting other parts. Probably it supervened on the condition of low vitality induced by the nephritis."

Pericardium and heart were normal. There was congestion of the mucous membrane of whole alimentary tract from œsophagus downwards, with some abrasions about the cardiac end of the stomach. The peritoneum was thickly covered with tubercle, which seemed thickest on the under surface of the diaphragm. There were tubercles on the capsules of the liver, spleen and pancreas. This, then, is a case of acute nephritis in which there was no doubt as to the nature of the inflammation of the serous membranes.

Inflammation of the peritoneum not following paracentesis is, as is well known, a rarer complication of Bright's disease than inflammation of the pleura or pericardium, but not so rare as inflammation of the meninges. Besides the case of the woman, just related, who had tubercular peritonitis, I have found between the years 1894–1900 only two other cases of this complication in acute nephritis. Both of these were in boys, one six years old, the other seven. Both patients had pleurisy (not empyema) as well as pertitonitis, and one had bronchopneumonia also. Both had severe pyrexia and severe diarrhœa, and in both there was tenderness of the abdomen and abdominal pain, which came on in each case in the sixth week of the illness. In both instances the peritonitis was suppurative. In one case the condition was diagnosed after paracentesis abdominis, and it is interesting to note that paracentesis relieved the pyrexia. In the other case, as far as one can gather from the report, the condition was not diagnosed. Paracentesis had not been performed, and a thin purulent fluid was found in the peritoneum after death. It should be noted that in both cases the œdema was great and persistent. In both instances it got better at first, but then got worse again before the peritonitis set in.

Regarding the relative frequency of peritonitis in acute tubal nephritis as compared with pleurisy and pericarditis, authorities differ. All are agreed that pleurisy is the commonest. Fagge and Pye-Smith, as a result of experience at Guy's Hospital, say peritonitis is the rarest. Grainger Stewart published a series of cases observed by himself in which pleurisy occurred in 14 per cent., pericarditis in 7 per cent., and peritonitis not at all. But he quotes two other series from German writers in which the figures are, in one, pleurisy 12 per cent., peritonitis 11 per cent, pericarditis 4 per cent., in the other, pleurisy 16 per cent., peritonitis 8 per cent., pericarditis 7 per cent., so that these two series make peritonitis a commoner event than pericarditis.

With the exception of peritonitis it appears that these serous inflammations seldom suppurate. Peritonitis

apparently often suppurates. Fagge and Pye-Smith, for instance, state that sixteen cases of acute peritonitis occurring in the course of Bright's disease were observed in Guy's Hospital in the nineteen years from 1854 to 1872. "The inflammation," they say, "was generally suppurative, and there was often a marked absence of vascular injection of the serous membrane. The kidneys were, as a rule, enlarged, and in a more or less advanced stage of tubal nephritis, but in three cases they were contracted and granular," This particular event, therefore, of suppurating peritonitis appears to be much commoner in tubal nepritis than in granular kidney.

The frequency of purulent pericarditis is disputed by authorities. Dr. Fagge said that he had never seen a case of purulent pericarditis in Bright's disease. But Dr. Pye-Smith quotes Dr. Sutton as saying that purulent pericarditis is very common, and almost characteristic of Bright's disease. Dr. Bradford also, in Clifford Allbutt's System, says that pericarditis is more liable to become purulent than peritonitis or pleurisy. I do not know what the Guy's Hospital records would show as to the frequency of this complication in all cases of Bright's disease, including therein acute and chronic tubal inflammation, and granular disease, but in the seven years, 1894–1900, there was no case of this complication of acute tubal nephritis.

Empyema is on all hands admitted to be a very rare complication of Bright's disease. Besides the man with whose case I began, and who had suppurative peritonitis as well as empyema, I found only one case of empyema complicating acute Bright's disease in the hospital records for recent years. This was the case of a man of seventeen whose nephritis followed a chill. Empyema occurred early in the disease (having been induced very likely by the same chill which brought on the nephritis), and was successfully relieved by operation. It was four months, however, before the albuminuria cleared up, and about the middle of this period the patient had uræmic fits, accompanied by pyrexia. The pus from the empyema was bacteriologically examined and found to be pneumococcal. The urine was sterile.

Meningitis is apparently a very exceptional complication, and I did not find any case of it. Dr. Pye-Smith mentions one case seen by him, of a young man, who died from acute nephritis and purulent meningitis, with entire absence of traumatic, or other local cause, for the complication.

The pathology of serous inflammations in renal disease has given rise to much speculation. The older writers put it down to the undepurated state of the blood, and they supported this contention by injecting urine and urea into the circulation of animals. Pleurisy and pericarditis often resulted, but I do not know how long it took to produce these complications, and, as the experiments were made before the days of bacteriology, no investigations in this direction were made on the diseased tissues. The experiments do not exclude the possibility of a secondary bacterial infection.

The most recent tendency seems to be to ascribe them to secondary infection, especially if they occur in the last days of the disease. Dr. Bradford, for instance, holds this view, and Osler appears to adopt it very strongly. Osler devotes a page of his book to the discussion of what he calls "terminal infections," and begins the discussion by quoting the remark that patients rarely die from the disease from which they suffer. He groups Bright's disease along with heart disease, cirrhosis of the liver, and other chronic diseases, and says that these are the diseases in which terminal infections occur. Excluding tubercular cases, it has been found that the streptococcus pyogenes is the commonest infective agent. Others are, the pneumococcus, staphylococcus aureus, bacillus proteus, gonococcus, bacillus coli communis, and bacillus pyocyaneus.

It would be interesting to know whether the relative frequency with which these organisms occur, is the same for all serous membranes. For our present purpose it would be particularly interesting to know in what proportion of cases the bacillus coli communis is the active agent in causing peritonitis. Many writers seem to ascribe the peritonitis of Bright's disease to this organism alone. The majority suppose that the organism gets into the peritoneal cavity from the bowel, without any gross lesion of the latter, but simply because the resistance of the tissues in general is lowered by disease. One writer suggests that the bacillus escapes from the bowel through the ulcers and excoriations of the colon which sometimes occur. Ulcerative colitis is, however, a rarer event in acute than in chronic nephritis or granular kidney, while peritonitis is commoner in the acute cases than in the others. There would seem, therefore, to be no special risk of peritonitis in cases in which ulceration of the intestinal mucous membrane occurs. On the other hand, peritonitis has often been observed apart from ulceration of the bowel.

The name "terminal infection," used by Osler, will not cover all cases of inflammation of serous and other membranes in Bright's disease, for in many instances the inflammation begins almost with the disease, and often, when it occurs later on the patient recovers. Are these cases to be regarded as of a different nature from cases where the serous inflammation is actually terminal? Or are they too caused, not by the irritation of poisoned blood, but by the presence of the ordinary infective micro-organisms? It certainly seems more reasonable to adopt the same pathological explanation for all cases. It is likely enough that cases of Bright's disease, complicated from the beginning by bronchitis or pleurisy, as is so often the case in children, are really instances of a double infection, the same chill having been the starting point of both complaints. It is common enough, for instance, to find facial erysipelas complicated by acute bronchitis, both being justly ascribed by the patient to a single definite exposure to cold. There is little doubt that such cases are examples of a double infection, and it is not improbable that, in some instances, the inflammatory complications of Bright's disease are of the same nature.

The only way to settle the question is of course by a careful bacteriological examination, both of inflammatory fluids withdrawn during life, and also of the tissues of the dead. Such examinations do not appear to have been made at Guy's Hospital, at all events down to the end of the year 1900. But even if such bacteriological investigations had never been made by anybody, there are at least three facts which would seem to afford strong à priori reason for believing that whatever may be the ultimate pathology of tubal nephritis, the inflammations of other tissues which so often accompany it, are due, not to any occult influence of the blood, but to the same organisms which ordinarily cause these tissues to inflame, when no renal disease co-exists.

First of all, there is the fact that the relative frequency of the different forms of inflammation, not only of serous membranes, but of other tissues, is precisely the same in patients who have nephritis as in those who have not. In Bright's disease, for instance, the commonest concomitant inflammation is bronchitis; pleurisy comes next, then pneumonia, then pericarditis, then peritonitis, and last of all meningitis.

A second fact is, that the special liability of patients of different ages to different forms of inflammation is the same whether they have Bright's disease or not. This is indicated more or less by the cases I have collected. Thirty of these cases were children under 16, and of these, 3, or 10 per cent., had pneumonia. Seventy were over 16, and only 2, or 3·3 per cent., had pneumonia. Again, two cases of this series had facial erysipelas: one was a man of 40, the other a man of 45. In both cases the erysipelas came on a few weeks after the patients were in bed and under treatment for acute nephritis. Both of them died, and the diagnosis of acute tubal nephritis was therefore confirmed post-mortem.

The third fact, which seems to point in the same direction, is the constant association of these inflammations with excessive and persistent œdema. Thus, they are commoner in cases of large white kidney than in acute cases, and in acute cases they are commonest when the œdema is great and lasts a long time, or repeatedly recurs. This is illustrated by the four cases of peritonitis which I have mentioned. In the first case the œdema was so excessive that it persisted for some weeks after the albuminuria had ceased and the renal inflammation had presumably come to an end. The second case (the woman who had tubercular peritonitis and pleurisy) was complicated by cirrhosis of the liver. This led to an unusually severe ascites, and, as will be remembered, the post-mortem demonstrator was struck by the fact that the peritoneal tubercles were apparently of older date than those on the pleuræ, *i.e.*, the most œdematous tissue was the original seat of the secondary infection. In the other two cases, the œdema only partially subsided for a time; it recurred again before the peritonitis set in.

I do not overlook the fact that cases of acute nephritis are occasionally complicated by bronchitis, pleurisy, or pericarditis from the beginning, when the œdema has not lasted a long time and when it never becomes very great. These I take to be cases of original double infection. Apart from these cases there seems to be no doubt that if a patient is originally attacted by acute tubal nephritis alone, and if, as happens in the great majority of cases, the œdema subsides in a week or two, there is no special liability to secondary infection, even though the passage of albumen and casts may continue for months. If, however, the œdema persists in large quantity for six weeks or more, the liability to a secondary infection is very great.

It is easy to understand the association of bacterial inflammations with persistent œdema. The tissues in these cases are sodden with a stagnant fluid which is foreign to them and practically excrementitious. This fluid forms an excellent culture medium. It is never cleansed as the living tissues are, by the blood, and if bacteria reach it, they flourish unmolested. The occurrence of inflammation in œdematous tissues is no more surprising than the occurrence of cystitis in a paralysed bladder, or the occurrence of gastritis and dyspepsia when the stomach is dilated and atonic.

The evidence certainly seems to point to persistent œdema as being the chief factor in determining the onset of inflammation in acute nephhritis. But there are undoubtedly other factors, for the œdema of nephritis is more liable to be followed by inflammation than the œdema of other diseases, *e.g.*, heart disease or cirrhosis. The greater deterioration of the blood in nephritis may be the cause of this, *i.e.*, its germicidal power is so reduced, that bacteria entering it are less likely to be effectually dealt with in a short time, and therefore more likely to find their way to any œdematous fluid which may exist in the body.

This, gentlemen, concludes my paper. I have tried to illustrate, by cases drawn from the Guy's Hospital Medical Reports, the occurrence of a somewhat rare complication of acute nephritis, viz., peritonitis. I have only been able, after a prolonged search, to produce four cases, but all of them show how this complication supervenes on extreme œdema. I think the association of this and other inflammations with great œdema, is a strong reason for believing the modern view, that these inflammations are really due to ordinary bacterial invasion, and are not caused by the chemical or mechanical irritation of the vitiated blood, which results from the nephritis.

Papers by Guy's Men.

A Case of Appendicitis in which the Appendix was lodged in, and adherent to, the Femoral Canal. By J. H. Galton, M.D. Lond.—*The Lancet*, 29th March.

A System of Radiography. By E. W. H. Shenton, M.R.C.S., L.R.C.P.—*The Clinical Journal*, 26th March.

A Clinical Lecture on the Treatment of Infantile Paralysis. By F. J. Steward, M.S., F.R.C.S.—*Ibid.*, April 2nd.

Types.

VIII.—The Mediocre Man.

"And in the midst of all this stood Mr. Pickwick, his face lighted up with smiles . . . himself the happiest of the group, shaking hands over and over again with the same people."

Posthumous Papers of Pickwick Club.

After a lengthy search through the labyrinth of our hospital, wearied by many a stair and negative answers to my fond enquiries for the man I sought, I heard a peculiar, mellow laugh.

My heart leapt with joy; for I knew that he was near. So, indeed, he was. There in the colonnade, who should stand but the incarnation of Mr. Pickwick. A small figure, but noble withal, surrounded by a group of admiring friends. One hand was thrust deeply into his pocket, and the other firmly grasped a straight pipe, relieving his mouth for the time while he gave vent to the laughter which had attracted my attention.

Some deep words of wisdom, concerning typhoid fever and allied conditions were falling from his lips, when I apologised for my interruption, and took him by the arm in the manner which he knows so well, and led him gently down the steps into the Park.

"Forgive my intrusion, sir," said I; but he stopped me short, and replied, politely but firmly, "Do not mention it, sir. I myself am only a mediocre man. I do not belong——" "To the great men of this hospital," I suggested. "No," he replied, "I do not; nor do I belong to the Rugby Football Club, and, I might add, I do not belong to the Ladies' Hockey Club."

"Really!" was the only word I could think of, in my surprise, when he once more repeated, in an abstracted tone, "I am only a mediocre man."

"But," I insisted, "you are a great musician?"

"No, I should not describe myself as great. I am a med—; I mean I play the piano a little, and, at times, I——" "Sing." (I forestalled him). "Yes," he replied, and after a lengthy pause, and with due solemnity, he added, "at times."

"Indeed, you do, sir, for I have heard you and have seen you on the stage."

"Yes, I once took a small part—quite a small part—and my appearance caused some merriment, I think."

As the hospital was still ringing with the accounts of his great speech, I thought that the world must be informed of his training in the art of elocution, so I put a few questions to him regarding it.

"I had no training," he answered, modestly. "It came to me all of a sudden, so to speak; and at times—yes, at times—it comes back again."

"You have heard my ideas on the treatment of the typhoid patient," was his next proposition. I said that I had, and I understood that it was the patient, and not the fever, that should be the object of treatment. He hailed this with delight, and said, "That is so. We do not treat typhoid fever, we treat the typhoid patient;" and, after a long pause for breath and oratorical effect, "So, also" (another pause) "we do not treat insanity, we treat the insane person."

All my old dread of lectures came back to me in an instant, and I suggested that we should adjourn for a drink.

He looked aghast, and said, "Beware, young man; all the evils of this world are loosed by—." I quite agreed with him, and said that it was possible.

"Yes," he replied, entering his room, and closing his casement on the wicked world, "to the alcoholic all things are—"

I *felt* chastened, and went away.

WILD CATS.

Correspondence.

To the Editor of Guy's Hospital Gazette.

A Literary Club.

Dear Sir,—Mr. Ormond's letter in your last issue must have attracted much attention, and it is to be hoped many will inform you of their views upon its subject.

A *Literary Society, though it may be ideal in theory*, is not an easy thing to make a practical success. The meetings of such a society should aim at something more than mere instruction in literary matters. They should, if possible, combine with such instruction a truly social element, a gladness of its members when about to meet together, and an after-feeling that the evening has been enjoyed. There will probably be many and various opinions as to how these ends are best achieved. The following is an account of how they have been successfully attained elsewhere.

At a certain college all the men who entered in October met together and formed the "Mermaid Club," taking the name from the literary "Mermaid Tavern." The intention was quite as much to cause the men to know each other better as to be extremely earnest in literary pursuit. At stated intervals there were meetings. These were held in different members' rooms in turn—coffee, aërated waters, whisky and tobacco being the only supplies allowed. At each meeting some well-known play was read; whether Sheridan, or Goldsmith, or Ibsen, or whoever else, had been settled at the previous meeting, and each member present read a part allotted to him. The parts, as far as possible, were read to suit the character represented. The allotment of the parts was made beforehand by the president. At Guy's, the president for the evening might be the person in whose room the meeting was to be. Notice of the meeting, of the play to be read, and of the part he was expected to read, was sent to each member by the secretary. To defray the cost of notices, a small subscription (2s.) was annually required, and this was collected by the treasurer.

In this way a large amount of drama reading was carried out each winter, and with benefit. At the same time, the evenings were never dull, and the members got to know each other the better for them.

It will be urged that, with many members, a play contains too few parts to go round; but at Guy's, with its busy wards, it is quite likely that members will often have more parts than one to read.

Since parts must be allotted, it is necessary to know definitely what members are likely to be present. It will be urged that the society must therefore be selective, and not open to all, but surely no such result need follow. Any Guy's men who cared for the society could join it freely, even though, from time to time, they might be listeners without a part to read.

The drama, it may be said, is not the part of literature most Guy's men would care to learn about. In that case, a "Mermaid Club" at Guy's need be no further advocated. It is but a suggestion, and may, perhaps, help the discussion which you have opened in the Gazette. It is a suggestion, however, which has once worked well, and, with modifications, perhaps, it might work well again.—I am, yours sincerely,

ONE OF US.

Dear Mr. Editor.—I have read Mr. Ormond's letter with interest, and should like to be allowed to contribute the following suggestions to the discussion of the subject which no doubt will ensue. To make such an undertaking as the founding of a literary society successful among a number of men for the most part not specially interested in literature, will require much energy and very careful organization. As to the lines on which such organization should work, may I sketch the following scheme? The society proper should be small and consist only of those men who have some knowledge of literature and take a real interest therein. Though I know that Guy's men have enough in the way of subscriptions to satisfy them, yet I am of opinion that a small subscription should he collected, as tending to give actuality to the society. The meetings should be private (*i.e.*, limited to subscribing members), should take place say twice a month during the winter, and should be devoted to the consideration of some particular period, author, or work. The study of the same subject should be extended over a series of meetings, and should be founded on the reading done by individual members between whiles. No meetings at which plays are read should be held, such proceedings being merely ridiculous. Besides these meetings the society should organize at least two large meetings during the season to which all Guy's men, and possibly the Staff and Sisters should be invited. At these some well-known man of letters should be asked to read a paper—if possible papers read at the last public meeting should bear on the subject which the society has recently been studying. This would, perhaps, enable a few members to comment rationally on the lecturer's remarks. I think some such scheme as this would fulfil a double purpose. The private meetings would genuinely encourage and assist those men who are naturally interested in literature, while the public meetings would tend to give the society a conspicuous place in the Guy's world, and also be a source of interest to many, who, without any special enthusiasm for literary pursuits, are glad of an apportunity of hearing a well-known man talk about some subject outside the scope of their professional training.—I am, yours truly,

F. B.

Dear Sir,—I trust you will pardon my intrusion into your columns with a letter on the above subject, and that Mr. Ormond will pardon any stray remarks of mine which are not quite favourable to his idea. I had almost written "scheme," but on looking again at his letter, I

perceive that he hasn't got one; from motives of modesty or caution, he has left practical details to others. There has been some talk lately about founding a literary "academy" in London; but as far as I can gather, the only point on which all are agreed is that all previous institutions of this sort have been failures, and if the proposed academy is to succeed, it must carefully avoid all resemblance to any of the established literary societies in the world. I think Mr. Ormond and his supporters would do well to consider this. No doubt most people think that to get together a committee, to elect officers, and to arrange meetings, is to form a society. But I fear that it is when all this has been done that the difficulties begin. Supposing even that a preternaturally strong committee, with an abnormally active secretary, had actually arranged for series of papers to be read—*and seen that they were written*—had whipped up a sufficient audience for each meeting; had collected subscriptions for the inevitable coffee and biscuits—what then? I think I can guess the percentage composition of the various papers. Fifty per cent. will be devoted to shewing that, say, Milton and Shelley and Keats were great poets, and much neglected by the average medical student. Twenty per cent. will be occupied with Mr. George Meredith and Mr. Thomas Hardy, and prove conclusively that they equal or surpass the greatest of their predecessors. Another twenty per cent. will deal with some minor Elizabethan or Jacobean writers, with examples culled from a half-crown volume of "selections;" whilst the remaining ten per cent. will deal with a "period" distilled from one of Dowden's Essays, with a flavouring from the Encyclopædia Britannica. Each reader in turn will remark that he has not had time to prepare his paper; the subsequent speakers (if any) will veil ignorance in levity, and the loafers who stroll in at coffee time will join in the usual votes of thanks. Next year, the Secretary will be doing a house appointment and the committee be up for examinations, and no more meetings will be held.

Will this sort of thing do much to encourage the study of literature? It seems to me, sir, that those who have the inclination can study literature quite as well without it, and those who have not the inclination, will only be further strengthened in their original attitude.—I am, dear Sir, yours faithfully, J. M.

Dear Sir,—In reference to the letter which appeared in your last issue proposing the formation of a "literary society," I would suggest that at first, at all events, the meetings of such a society should be as informal as possible, and be held in the rooms of members. Let the widest interpretation, too, be placed on the word "literary," and let it include any subject which does not savour of the "shop."—Believe me, yours truly,

N. BLAKE ODGERS.

The College, Guy's Hospital,
April 8th, 1902.

Novelties.

Samples of a new preparation of Bovril, intended more particularly for invalids, have been recently tried in the wards. The result has been very satisfactory, the patients taking it more readily than beef tea, its absolute freedom from fat make it especially useful in cases of vomiting. Of its great value as a sustaining stimulant there can be no question.

Sport.

Guy's Hospital Swimming Club.

The Annual Meeting of the Guy's Hospital Swimming Club was held on Thursday, March 20th, in the Anatomical Theatre, at 4.30 p.m. Mr. Fripp took the chair. The Hon. Sec. read the minutes of the last meeting and presented the balance-sheet, which showed a balance of £2 0s. 2d.

The following officers were elected for the ensuing year:—President: A. D. Fripp, Esq., M.S. Vice-Presidents: L. A. Dunn, Esq., M.S., J. Fawcett, Esq., M.D., W. R. Wood, Esq., L.D.S., M.R.C.S. Captain: A. L. Moon. Vice-Captain: L. U. Ransford. Hon. Sec. and Treasurer: R. B. Dawson. Committee: S. M. Saunders, H. Wight, J. Cameron, T. B. Layton, C. H. Reinhold.

Births.

COLEMAN.—On April 3rd, at Sutton Bridge, the wife of J. G. B. Coleman, L.R.C.P. Lond., M.R.C.S., of a son.

GROVE.—On March 23rd, at St. Ives, Huntingdonshire, the wife of W. Reginald Grove, M.B., of a son.

HOVENDEN.—On April 7th, at Kitson Lodge, Barnes, S.W., the wife of Gerald S. Hovenden, M.D., B.S. Lond., of a daughter.

Marriage.

WALTERS—BATTCOCK.—On April 3rd, at Luke's Church, Maidenhead, James Hopkins Walters, M.R.C.S., L.S.A., of Reading, to Hylda Margaret Vowe, younger daughter of George Arthur Battcock, of Ambler House, Maidenhead, Berks.

Deaths.

BROWN.—On March 28th, at Newlands, Crawley Down, Sussex, Robert Brown, F.R.C.S., in his 82nd year.

CADDY.—On March 21st, at Charterhouse, Lion Gate Gardens, Richmond, Surrey, John Turner Caddy, M.D., Inspector-General, R.N., in his 81st year.

Ed.—D. G. G.

Contents.

	PAGE
Some Abdominal Tumours: Clinical Lecture by Dr. Taylor	165–171
A Fatal Case of Angina Ludovici following Dental Caries	171–172
Danger of the Douche	172
Novelties	172
In Lighter Vein	173–174
Appointments	174
Obituary: Dr. G. E. C. Anderson, Major S. A. Stuart	174
Passim	175–177
South African Memorial Fund; Eighth Subscription List	178
Reviews	178
Removal of the Dental Pulp: By E. Field Beck	178–181
Papers by Guy's Men	181
Types	181
Correspondence: South African Memorial Fund, The Fives' Court	183
Nursing News	184
From the Gazette's Special Pathologist	184
Sport: Association Football—2nd XI.—Report of Season	184

Notice.

All Communications, Articles, Letters, Notices, and Books for Revie should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold will be One Shilling and Sixpence.

Calendar of Coming Events.

April, 1902.

Sat. 26.—Messrs. Symond's and Steward's take-in; Drs., C. H. Bubb and H. Johnson; Cl., F. L. Thomas.

May.

Thur. 1.—Messrs. Lucas and Lane's take-in; Drs., J. T. Hicks and N. I. Spriggs; Cl., G. T. Wrench.
Summer Session begins.
Probable date of Primary Fellowship Exam.

Fri. 2.—9 a.m., Dr. Washbourn lectures on Bacteriology.
1.15 p.m., Clinical lecture by Mr. Lane.

Sat. 3.—G.H.C.C., I., v. London County C.C., home.

Mon. 5.—Practical Dental Exams. for Prizes begin.
Extractions at 9 a.m.
Final M.B. Lond. Exam. begins.

Wed. 7.—1.30 p.m., Clinical lecture by Dr. Bryant.
9 a.m., Dr. Washbourn lectures on Bacteriology.

Thur. 8.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. Moyle and C. M. Anthony; Cl., W. H. Bowen.

Fri. 9.—1.15 p.m., Clinical lecture by Mr. Lane.
1st Professional and Final L.D.S. Eng. Exams

Sat. 10.—G.H.C.C., I., v. Beckenham, away.
II., v. Old Charlton, away.
III., v. Enfield Lock, away.

Guy's Hospital Gazette,

APRIL 26, 1902.

Some Abdominal Tumours.

CLINICAL LECTURE BY Dr. TAYLOR.

March 8th, 1902.

Gentlemen,—To-day, I am going to speak of some cases of abdominal tumour. The first case is that of a boy, three and a-half years of age, who was admitted on February 24th. He began to be ill three months ago, with pain in the abdomen. He lost his appetite, and his bowels became constipated, being opened only every two or three days. The motions were sometimes slimy, but more often hard. Soon after Christmas, 1901, the abdomen commenced to swell. The swelling has increased gradually, more in the last month, and more still in the last week. For the last day or two he has not complained so much of pain. The patient's mother states that he has lost flesh. For the last two months he has lived chiefly on bread and butter and fish.

Condition on admission.—Patient is a weakly boy, and somewhat emaciated. Pulse 120; temperature 99·4°; respirations, 40. The abdomen is distended, being most enlarged in the antero-posterior direction. The umbilicus is only slightly depressed, and the abdomen moves very little on respiration. On palpation the abdomen is tense. There is no fluctuation, and a thrill cannot be obtained. In the upper part of the abdomen three masses can be felt, which are ill defined from one another. The most definite mass is in the right hypochondriac region. This is firm, and has a hard, sharp edge, very much in the position of the edge an enlarged liver. The edge commences at the tip of the eleventh rib; then runs downwards and inwards, being in the nipple line fully two inches below the costal margin; and ends in the middle line of the abdomen. To the left of this, and separated from it by an indistinct fulness, is a mass, which extends as far as the ninth rib on the left side. For about one and three-quarter inches below the ensiform appendix, nothing can be felt. Below these two

masses, and indistinctly separated from them, is a much larger and indefinite mass, extending to half an inch below the umbilicus. To the right it reaches to the nipple line, and to the left the lower border comes upwards and outwards to the eleventh rib. (*See* Fig. 1). No masses

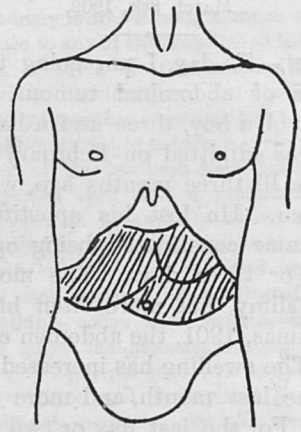


Fig 1.

can be felt in the lower part of the abdomen. The abdomen is generally resonant, and even over these masses the percussion note is not far removed from the normal. The abdomen does not now appear to be tender, nor does the patient complain of any pain in it.

When an abdominal tumour is recognised, we have, first of all, to think whether it is an enlargement of an existing organ, or whether it is a separate mass. You have always to consider, therefore, whether you have got an enlargement of the spleen, or of the liver, or of the kidneys, or, in females, of the uterus or ovary. Then if you satisfy yourself that the mass is not an enlargement of any of these organs, you have to determine whether it is connected with the hollow viscera, or is entirely separate; and then of what nature it is.

I think we can exclude from consideration both the liver and spleen in this case. The mass in the right hypochondrium is highly suggestive of liver; and the spleen might be imagined to be included in the left hand mass; but each mass is partially resonant, and beyond what has been stated in the description and what has been indicated in this diagram, is the fact that neither mass can be traced round in such a way into the flanks as an enlarged liver or spleen commonly can. Moreover it is impossible to distinguish the inner margin of the spleen and the opposed edge of the liver as they can be commonly recognised. It is certainly not one's ordinary experience to have such a combination of enlarged liver and spleen as to produce such a surface and outlines as we have here. I think we clearly have to look at some other source for the production of this mass.

Seeing that the patient is a child three and a half years old, the question of tubercular peritonitis presents itself as a very probable lesion. We know as a matter of experience that the tubercular process leads to infiltration of the peritoneal tissue with fibrous tissue and that masses of caseous and adherent glands form in such a way as to produce hard and large solid masses in different parts of the abdomen. Such masses present very considerably variations in their outline, and yet are to a certain extent characteristic. The more common varieties are these.

A great number of cases present masses in the lower part of the abdomen, with a rounded upper margin, level with, or not passing very much beyond the umbilicus. The surface is rounded, irregularly undulating, resistant, perhaps tender, but not much so.

Then there is a well recognised form to which the hard mass in the present case no doubt approaches somewhat closely, that is, a a broad band across the abdomen, somewhat above the umbilicus, which is due to infiltration of the omentum with tubercular and caseous material; such a band can be very readily mistaken, and has been mistaken, for an enlarged liver.

In a third variety the infiltration takes the form of a vertical band between the pubes and the umbilicus; and this arises from thickening and caseation of the connective tissue which surrounds the remains of the urachus or obliterated hypogastric arteries.

I have pointed out that the mass in this case is not completely dull. This indicates that

the mass is close to the surface and overlies some hollow viscus, such as the stomach or bowel; it does not penetrate deep down to the back of the abdomen, and must arise in some superficial tissue, such as the peritoneum or omentum. This is quite consistent with a diagnosis of tubercular peritonitis. The diagnosis is further strengthened by the facts that the patient is a child and that the trouble has come on more or less insidiously, and that there have been emaciation or loss of flesh and a general illness and feebleness coinciding with these changes in the abdomen.

The general condition of patients with tubercular peritonitis is very variable. One usually thinks of these patients as being emaciated and wasted, and so, of course, they are towards the end of their illness, but you must be prepared to entertain a diagnosis of tubercular peritonitis in cases where the patients are still moderately well nourished. When the disease has lasted a long time, when it has been under treatment and the treatment is unsuccessful, as it often is, then the patients will get emaciated, and you will have that more satisfactory evidence to form your diagnosis upon. The picture that one generally forms of a child who is suffering with tubercular peritonitis, is, that the patient has a very large abdomen and small legs, in fact with little else large about them. However, neither is that condition confined to tubercular peritonitis, nor is it in tubercular peritonitis always present throughout.

I have given some prominence to the fact of these masses occurring in tubercular peritonitis, because I think that it has not always been sufficiently present to the mind of the student. I remember well, at an examination some few years ago, showing to a candidate a small boy who had a big abdomen in the lower part of which there were very obvious masses of the kind that I am speaking of. The candidate was asked to examine this patient, not so much with a view to obtaining a diagnosis as to test his powers of clinical observation. I tried to elicit from him what he felt, and I could not get any very satisfactory answers, nor could I understand that he felt these masses, nor that he appreciated that there was anything materially wrong with the abdomen, except the fact that it was enlarged. The bell rang, and I said, "We must part; what is the matter with the patient?" He replied, "tubercular peritonitis." His diagnosis was happily correct; but he had quite failed to recognise the strongest evidence in favour of it, namely, the existence in the enlarged abdomen of masses of infiltrated and caseous peritoneal tissues.

But I must remind you that there are other forms of tubercular peritonitis.

There is one in which fluid effusion or ascites is the chief result. Such a form of ascites has to be distinguished from other forms of effusion, and it is liable to be confounded with ascites from cirrhosis in men, women and children, and with ovarian cysts in young women. Cases of tubercular peritonitis with effusion have been operated upon, under the belief that they were ovarian tumours.

A combination of ascites with infiltrated masses is sometimes described as a third form.

I have next to refer to a case which is in the ward, and which may be described as a case of abdominal tumour. But it is not a case that properly falls within our province, and will, no doubt, be removed to another ward. I only bring it to your notice in this connection without committing myself to any elaborate discussion of its nature. Mr. Targett has seen it, and regards it as one of perimetritis, or inflammation of the peritoneum in the neighbourhood of the uterus. The patient is a girl, aged 17, the history of whose illness is this: "Last November she went out in a fog, and came home with pains in her chest and abdomen. She went to bed, and was sick. Her doctor thought she might have enteric fever. A week later, she noticed a swelling in the right side of her abdomen. This increased in size, and a fortnight later suddenly disappeared. The disappearance of the tumour was accompanied by a copious discharge, apparently purulent, from the vagina. This discharge continued for from five to six weeks, and almost ceased at her last menstrual period a fortnight ago. Since then it has been slight." She came into the ward

about three months after the beginning of her illness, and she now has a swelling in the lower part of the abdomen mentioned. Above the pubes (*see* Fig. 2), there is a rather extensive firm

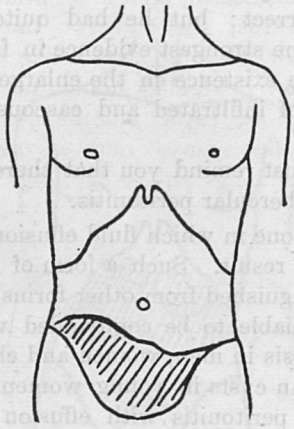


Fig 2.

infiltration, with a more or less well defined edge. The report states :—" On palpation, resistance is felt in the hypogastric region, and in both inguinal regions. This is of varying consistency, containing some harder indefinite lumps. Its upper margin is fairly sharply defined from the supple abdomen above it. It is not very tender. The skin over it is not red or œdematous. No fluctuation or thrill can be obtained."

If this had occurred in a child three and a-half years old, as our other patient is, we should not have considered the possibility of its being perimetritis ; but because it is in a young female adult that question naturally comes before us.

Women are subject to various inflammatory lesions about the pelvic organs—perimetritis or inflammation of the peritoneum, and parametritis, pelvic cellulitis, or inflammation of the tissue beneath the peritoneum. It is admitted that these conditions are closely related, and considerable difficulty must be experienced sometimes in distinguishing between them. The causes of perimetritis are mostly infections of the pelvic organs from without, sometimes gonorrhœal infections, sometimes infection in the course of menstruation and of puerperal changes, and, it may be, injuries from instruments used legitimately or illegitimately under various circumstances. Parametritis is also set up largely by injury and consequent infection. In either case, the effused products form masses which are hard and firm and perhaps tender, and which may result in suppuration and the discharge of pus, as in this case. On the other hand, the infiltration may be absorbed and the case may completely recover.

You might say, Have we satisfactorily concluded that this is not a case of tubercular peritonitis? Because it is surely not impossible that tubercular peritonitis may occur in a young female adult.

In both cases we may have a localised peritonitis; and not only that, but it frequently occurs that a general tubercular peritonitis has its origin in a primary infection of the broad ligament, Fallopian tubes, or ovaries. But the chief points which are in favour of the lesion being caused by other infection than that of tubercle, are the relative acuteness of the lesion, the fact that the uterus is fixed by the infiltration (which may, however, occur conceivably in tubercle), and especially the discharge of pus from the vagina, relatively early in the history.

In connection with these two cases I should like to mention, as illustrating the course of these inflammatory masses, a case which was in Clinical ward three years ago.

The masses, whether you call them tumours or not, which are formed by localised peritonitis, frequently become absorbed and disappear. We see this in appendicitis and in perimetritis; and even when the infecting agent is the tubercle bacillus, that is, when we have a tubercular peritonitis, recovery often takes place. The curability of tubercle is much more widely admitted than it used to be. The public have come to believe, perhaps too willingly, that any phthisis can be cured; and tubercular peritonitis has long been known to get well in many instances. The same is true of tubercle in other parts of the body, as for instance in joints, where it may disappear after patient treatment.

The case I was referring to is that of a young woman, twenty-four years of age. When apparently in good health she was seized with acute inflammation in the right iliac fossa. She

had pain, tenderness, some amount of swelling, obscure resistance, and ill-defined dulness, with some pyrexia. In association with that, after a little time, there were physical signs at the base of the right lung, indicating either pleurisy or superficial pneumonia. After a time, the resistance in the abdomen became more localised, and there was found a mass with an irregular, jagged outline, occupying the right iliac fossa. (*See* Fig. 3).

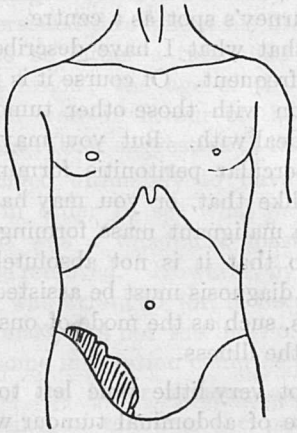


Fig 3

She was not ill enough to require immediate operation, and as a matter of fact she slowly and gradually improved, having never been, one might say, anxiously ill. That was in February, 1899. The case might have been appendicitis, peritonitis, or some local pelvic inflammation. There

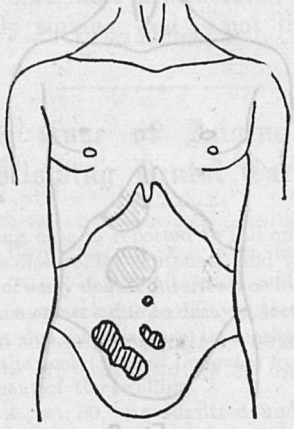


Fig 4

were particular reasons why no pelvic examination was ever made; but the early implication of the right lung made at any rate a pelvic lesion the least likely of the three. She went out, after many weeks, with the mass still present but considerably reduced in size. She continued in good general health, and in February, 1900, a year afterwards, she had two hard irregular masses below the umbilicus. She had, on my advice, strictly avoided doing any work. In September, 1900, seven months later, she had a single globular mass midway between the umbilicus and the pubes (*see* Fig. 5), and in

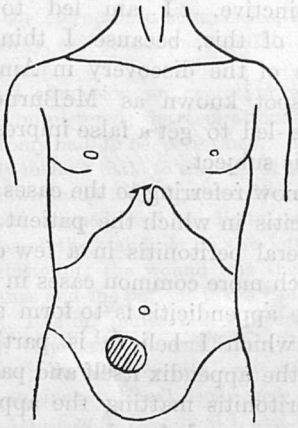


Fig 5

January, 1901, this was replaced by two quite small lumps a little lower down. (*See* Fig. 6).

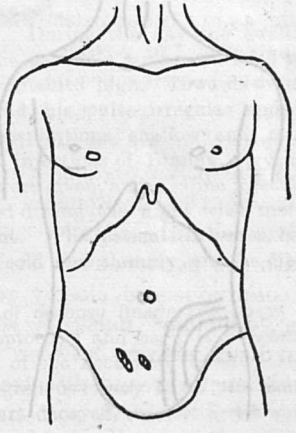


Fig 6

Six months after that, namely, in July, 1901, these two lumps were still felt, but were, I

think, smaller. My belief in regard to this case is that it was tubercular in origin.

In connection with this subject I have had to allude to appendicitis. It appears, indeed, that when our patient with perimetritis came to the out-patients, there were three possibilities discussed—namely appendicitis, perimetritis, and tubercular peritonitis. Now we may ask, what does appendicitis produce in the way of tumours. Appendicitis, in a great number of cases, produces an infiltration which is very characteristic, if not distinctive. I am led to make a great point of this, because I think that in consequence of the discovery in America of a particular spot known as McBurney's spot, students are led to get a false impression with regard to this subject.

I am not now referring to the cases of sloughing appendicitis in which the patient is carried off with general peritonitis in a few days; but to those much more common cases in which the result of the appendicitis is to form a localised infiltration which I believe is partly due to swelling of the appendix itself and partly to the adhesive peritonitis matting the appendix and cæcum together and forming a mass. That mass has very constant characteristics. It is more or less hemispherical in shape and extends inwards from the anterior superior spine of the ilium and Poupart's ligament towards the

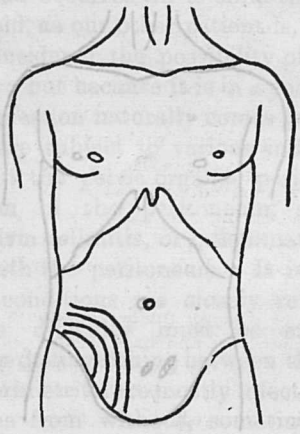


Fig 7.

umbilicus. In Fig. 7 are represented the outlines of four such masses of different sizes.

I have asked students sometimes at examinations, and in the wards, what is the shape of the tumour, and I have generally got an answer of this kind: an elaborate attempt on the part of the student to find out McBurney's spot first, and then a circle drawn round McBurney's spot. I think you will find that that is not clinical experience. I do not mean to say that you never do find a mass like that formed exactly round McBurney's spot as a centre. But I am quite sure that what I have described is very much more frequent. Of course it is interesting in connection with those other tumours which we have to deal with. But you may have in a child a tubercular peritonitis forming a mass very much like that, or you may have a psoas abscess or a malignant mass forming a similar tumour. So that it is not absolutely distinctive, but its diagnosis must be assisted by other clinical facts, such as the mode of onset and the duration of the illness.

I have got very little time left to speak of another case of abdominal tumour which is of very great interest, which is not in Clinical ward, but was in Philip ward, and is now in a private room. The patient, twenty-nine years of age, was admitted with a history of having been ill for a month or six weeks, and he came in chiefly because he was vomiting his food

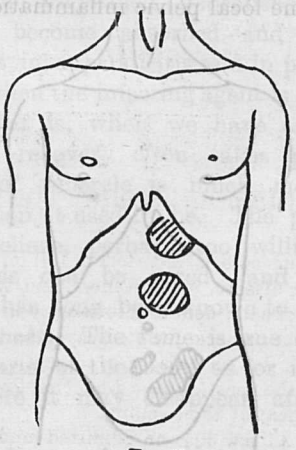


Fig 8

frequently and had more or less pain in the epigastric region. When we examined him we

found two masses, one above and to the left of the umbilicus, measuring two and a half to three inches in diameter and apparently solid. The other, above it, nearer to the costal margin, and losing itself under the ribs. It was uncertain whether these two masses were continuous or not. (*See* Fig. 8.) He was fed on milk and kept quiet, the vomiting ceased and he appeared to be much better. The temperature ranged between 99° and 101°, and this pyrexia persisted throughout his illness. It was thought to be either a tubercular lesion, or a malignant lesion; the age of the patient and the pyrexia were in favour of the former, the great extent rather suggestive of the latter.

We decided ultimately to have the patient explored, in order to see what was there, and whether it was a tubercular mass that could possibly be removed. However, by the time the operation was arranged for, it became obvious that that mass was not the limit of the growth, but that some infiltration could be tracked right and left of the lower tumour, and, therefore, the possibility of relieving the patient became less hopeful. The operation was performed by Mr. Symonds. He cut down upon these masses, and found that they were very widely spread, that they were continuous, and that they were not tubercular. They were behind the peritoneum, extending right down to the promontory of the sacrum, and they were obviously sarcomatous or malignant in structure. The patient is gradually sinking, and is not likely to live very long.

A Fatal Case of Angina Ludovici following Dental Caries.

The following case is reported in full on account of the rarity of the disease, its acuteness, and to illustrate the importance of early dental interference in cases of swelling of the face or neck due to decayed teeth.

Death was due, in this case, to septicæmia, following cellulitis of the neck (*Angina Ludovici*) five days from the commencement of the swelling.

Llewelyn A., æt. 30, was admitted under the care of Mr. Steward for swelling of the neck, trismus, and dysphagia. The patient had been troubled, more or less severely, for the past five weeks with pain in his left lower molar teeth. On April 3rd (two days before admission), the pain became much worse, and his face began to swell. He procured some gutta percha and filled the decayed teeth, the swelling, however, rapidly spread; later he came up to the hospital, and his condition being urgent, a stretcher was prepared in Samaritan ward as no bed was unoccupied.

Condition on admission.—April 5th, 1902, 6 p.m. (pulse regular, full, 96, temperature 98·4°, respiration 28). The patient is a robust, strong looking man; breathing laboured, no stridor; swallowing painful and difficult; the mouth can only be opened a quarter of an inch; the floor of mouth is swollen, and on a level with the tops of the lower teeth, and the tongue is fixed. The lower part of the face and the neck from the mandible to within two inches of the sternum, and as far back as the anterior borders of the sterno-mastoid muscles, are very much swollen, brawny, red, tender and painful. No fluctuation can be made out.

Soon after admission an operation was performed. A.C.E. was administered; the respirations suddenly ceased and trachetomy had to be performed. An incision was subsequently made a little to the left of the middle line extending downwards from the mandible; a little thin, very foul pus escaped, and on digital exploration, the inner surface of the mandible on the left side was felt bare of periosteum; the wound was then packed with iodoform gauze and the patient taken back to the ward.

April 6th, 10 a.m. (pulse 112, temperature 100°, respiration 24). The patient seems better, the œdema being distinctly less; he can, however, only open his mouth a quarter of an inch. Nasal feeds were ordered thrice daily (Milk Oj., Egg 1, Brandy ʒi.), and Creolin fomentations to be applied to the neck every four hours.

10 p.m. (pulse 120, regular; temperature 103·6°, respiration 28). The patient cannot open his mouth at all, and the swelling has increased on the right side. At midnight three incisions were made on the right side of the neck, Ethyl Chloride being used, from one of which a little pus escaped.

April 7th. During the day the swelling subsided a little and the patient's temperature fell to 100°, but the pulse rate remained high. Towards evening he became delirious, and his pulse irregular and feeble (130 to 150), and respirations shallow and rapid (30 to 46). Hypodermic injections of Brandy, Strychnine, Digitalis, and Ether were given, and a saline injection of four pints administered during the night with marked temporary improvement. The patient, however, became pale, his extremities cold and clammy, and he died at 3.40 a.m., April 8th.

Abstract of autopsy (made ten hours after death).—Blood—streptococci and bacillus coli communis present. The tissues of the neck were found matted together and almost gangrenous; very little pus present. Teeth.—Lower molars decayed, the left first lower molar being a mere shell and foul. No pus at the roots of these teeth. Mandible.—The inner surface on the left side almost completely bared of periosteum and necrosed. Mouth and tongue.—No ulceration. Ears.—Normal. Larynx

showed acute laryngitis. Trachea showed acute tracheitis both *above* and below tracheotomy wound. Pus was found tracking down the right side of the trachea. Bronchial glands.—Left normal, right suppurating. Pleura.—Recent pleurisy and hæmorrhages. Lungs.—Congested and œdematous, with commencing broncho-pneumonia in right lower lobe. Pericardium.—Parietal layer congested and ecchymoses present, a few minims of blood-stained fluid present in cavity. No pericarditis. Heart.—No endocarditis, muscle pale; weight 348 grammes. Liver.—Pale, yellowish patches on surface, weight, 2,198 grammes. Spleen.—Brown and soft, mottled on surface; weight 132 grammes. Brain and other viscera normal.

K. BLACK.

Danger of the Douche.

In the same number of the Gazette that contained that graphic account of Mr. Horrocks' accident on the Matterhorn, I published a short article under the above heading. The most severe and almost fatal case came under my own observation; two others were described to me by eye-witnesses. I have had recently under my care two other cases which make it clear that the use of the douche even in non-puerperal women may be attended with grave consequences. In the former cases the douche was employed after parturition and miscarriage; in the present instances one woman was certainly not pregnant and the other very doubtfully *enceinte*.

Mrs. R., æt. 30. This woman had had two children. From her own account I learned that she had suffered "excruciating agonies" at her confinements. Having overpassed a "period" by a few days, and dreading that she was once more pregnant she put "half a handfull" of alum into a jug of hot water, and using the vaginal tube of a Higginson's syringe, injected some of this fluid. At the second squeeze of the ball she was seized with a violent cramp in the abdomen, became collapsed, faint, shivery, and vomited—her neighbours thought that she was dying.

On my arrival an hour later I found the woman doubled up with pain, her pulse rapid, her face pale and anxious, the abdomen distended, and so tender that a touch caused a scream. The temperature was raised to 100° and rapidly reached 102°. The vagina was tanned by the alum, so that I deemed it advisable to wash it out with water. Morphia was given to alleviate the pain. For two days a general peritonitis was anticipated from her condition, when the symptoms rapidly passed off and she was well. A careful examination of the uterus now revealed a cervix that admitted the point of the finger, but whether the uterus was enlarged or not a bimanual did not enable me to assert. There was no thickening nor tenderness about the organ.

Mrs. C., æt. 37, has had one child, and is anxious to remain uniparous. To that end she used an injection of cold water again with a "Higginson," as in the other cases. She was taken with a sudden violent pain in the abdomen, and felt very faint. At the end of two hours she had much recovered. She did not consult a doctor for more than a month, when she sent for me. A tall, healthy, country woman. Her substantive complaint was that on getting into bed at night a cramp seized her in the left hypochondrium; that the muscles "stood up like knots," and that they subsided on rubbing. This had occurred almost every evening for some weeks. Bromides, which represented my mental attitude, were ordered, with much benefit. On my second visit a few days later, the above story of the injection was told me. Careful enquiry as to her former health and of the onset of her trouble from the moment of the douche leave no doubt as to their causal connection. Deep in the abdomen about the umbilical level, and to the left of the linea alba, could be felt a rounded, exquisitely tender mass, slightly movable, having its long axis parallel to the spine. The patient identified this as the point from which her pain always arose. The uterus was small, the cervix lacerated; there was no fixation nor any tenderness, nor tumour in the appendages. The tender mass was therefore apparently unconnected with the uterus. A normal menstrual period was just passed. It is difficult to conceive that the hydrostatic pressure obtained by a "Higginson" in the vagina (an open tube) should be sufficient to force water through the womb, the Fallopian tubes, and into the abdomen, the os uteri being not notably patulous. Such is the explanation of these accidents generally offered. No other appears possible when we consider the suddenness and severity of the onset in each case. To my mind, the resultant patch of peritonitis actually at some distance from the abdominal osteum clinches the diagnosis in the second case. Moral: Beware of the douche.

VAUGHAN PENDRED, M.D. F.R.C.S.Eng.
Buckingham.

Novelties.

We have received a specimen of China tea from the Cathay Tea Company, and, without hesitation, can commend its strength and quality. It, of course, does not make such a dark infusion as Indian and Ceylon teas, but it seems to contain good stimulating properties and a minimum of tannic acid. From this fact it is well suited for general use, and particularly when tea containing much tannin is not well borne, as in dyspepsia.

Bovril Ltd. have sent us an excellent little book of diet charts, which may be torn out and handed to patients. There are several different forms adapted to diseases especially requiring dieting, from which different foods can be struck out if thought injurious, and if given, a space is left for the amount and frequency of the food to be filled in, thus effecting a considerable saving in time over writing out a list of foods allowed to a patient or patients.

In Lighter Vein.

A GUEST OF THE RESIDENTS.

With a clatter of hoofs, my cab drew up before the main entrance of the Hospital, and I alighted. I slipped four shillings into the cabman's hand, and he thanked me. I had always heard that it was peculiar to the London cabman to swear when he was shown any money—and I wondered. A dear little gentleman in a frock coat and gaiters greeted me. I suppose he must have been one of the Governors of the Hospital. The tone of his voice had a mousetrapy flavour, like Dutch cheese! "What did I want? Fourth door on the left, if it was physic; first door if I wanted anything else." I was to dine with the Resident Medical Staff, I explained.

I had never been inside a hospital before, and am innocent of the ways of medicine men. My ears were sharp set for the moan of the suffering, and in my mind's eye I could see the large, bland eyes, and soothing hand of the saintly H.-S., and hear the honeyed tongue of a sympathetic H.-P.

I presently found myself in the dining hall, seated by the President. Here I was, in the very camp of the profession. The proudest moment of my life had come.

My eyes instinctively wandered from face to face as I allotted mentally to each a generous share of the Christian virtues. Opposite me sat a large man, with fair, open countenance, who, by the remarks he passed upon his chicken, must have been an eminent surgeon. The terms he used were without meaning to me; but I caught the phrases, "osteoarthritis" and myositis ossificans," and he seemed to be addressing them to his bird almost revengefully. I noticed he wore a little tuft of fur in his button-hole, and was sometimes addrresed as M.C.H., which I suppose meant that he was a member of the body of Church Helpers.

On my left, I caught an occasional glimpse of a face that excited my warmest curiosity. It was only now and then that I could see the whole of it, as it was largely screened by a number of black bottles, which, I suppose, contained some natural mineral water; a forehead so clear and high, and features so sharp, surely indicated a need for the purest aliment. Imagine my astonishment, therefore, when he called loudly for a haggis. I afterwards perceived a large bruise upon his jaw, and this threw some light upon the mystery of his digestion. He was evidently one of those quiet and self-contained men and I scarcely heard him order a whisky and soda; my astonishment was great, however, when, after its arrival, his face flashed up angrily as he roared, "Hoot, mon, and whurres the whusky?"

An incident presently occurred which I could not rightly interpret. A peculiarly innocent looking gentleman on the President's left made some homely remark about an elegant silk cushion that was in use at the table. I quite well understood what he meant—he was evidently interested in embroidery, and I had previously noticed he himself was wearing pink socks. The remark was no sooner uttered than the President turned sharply upon him, and demanded if it was his intention to insult the chair; to which my innocent friend quickly replied, gently closing one eye, "Far be it from *me*, sir. to cast any aspersions on the character of the President. But—" here he uttered an inarticulate cry, and snatched a large piece of bread from his hair—which, I suppose, had become entangled there—and held it up in mute appeal to the President. I can only suppose the dear, good fellow was practising a little gentle conjuring, to please the children in his wards.

Upon my right were seated two gentlemen who attracted my attention not a little. My immediate neighbour was evidently an invalid, for he found it necessary to send back most of the dishes that were brought to him. The other, I understand, was a capitalist, having refused a vast sum of money for a property of his called "The Thieves' Kitchen." One other gentleman at table interested me by his apparent unlimited consumption of bread. What he did with it all I could not guess; but his face was round and red, and his laugh quite too healthy for a simple vegetarian.

After a toast—and coffee, accompanied by a few hymn tunes that were new to me, I bid my hosts good-bye, and left, wondering what must be the stupendous services rendered to humanity by the man who was elected President of such a distinguished gathering, and to whom all men paid homage.

ARMADILLO.

Heard at the Telephone in the College.

Head Nurse (*loq.*): "Will you ask Mr. —— if he wishes No. 16 to be awakened for the I. M. H.?"

Doctor's wife (*loq.*): "Where is the Doctor, Mary?"

"In the 'Consoling' Room."

Intelligent artisan (entering front surgery, waving medical cutting from *People*, relating the cure of cancer by X-Rays): "Look here; 'ow do you sell 'um. I want a bottle. (Collapses at sight of Crooke's Tube.)

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants in Medical Wards.—Messrs. J. B. Copland (Dr. Taylor); H. T. Palmer (Dr. Hale White); G. Warwick Smith (Dr. Pitt); A. J. Beadel (Dr. Perry).

Clinical Assistant in Surgical Wards.—Mr. F. C. Robinson (Mr. Jacobson).

Ophthalmic Dressers.—Messrs. C. M. Murray, W. H. Brailey (Mr. Higgens, May 1st); F. M. V. Smith, G. Buckeridge (Mr. Brailey, May 1st); O. W. Richards (Mr. Higgens, June 16th); A. P. Piggot (Mr. Brailey, June 16th).

Surgeons' Dressers.—Messrs. C. H. Dawe, C. H. Reinhold, F. H. Wallace, J. T. Hicks, N. I. Spriggs, H. M. Woodward (Mr. Lucas); J. Bromley, R. Moyle, H. W. Bethell, C. M. Anthony, E. N. Jupp, R. Willan (Mr. Golding-Bird); F. C. Knight, H. D. Smart, H. Watts, E. L. Ward, A. R. Brailey, D. R. Pike (Mr. Jacobson); H. E. Morris, W. H. Bush, H. B. German, R. Larkin, H. C. Winckworth, J. S. Cooper (Mr. Symonds).

Dental Surgeons' Dressers.—Messrs. J. C. O. Bradbury (May-June); G. Moir (June-July); D. H. Trail (July-August).

Externs.—P. W. Hamond, B. Glendining, B. H. Wedd, J. M. Bickerton, H. S. Brown, E. H. Griffin, (May); J. Braithwaite, P. C. V. Bent, F. W. Fawssett, E. G. Goldie, L. S. H. Glanville, R. G. Anderson (June); C. E. Adams, H. R. Grellet, E. H. B. Milsom, O. B. Travers, C. F. Fraser, W. W. Read (July).

At the quarterly meeting of the Council of the Royal College of Surgeons of England, held on the 10th inst., Mr. C. H. Golding-Bird was elected a Member of the Court of Examiners Section of the Board of Examiners in Dental Surgery.

NAVAL AND MILITARY.

Surgeon A. J. Wernet, R.N., has been appointed to the *Sutlej*.

Lieutenant-Colonel Henry J. W. Barrow, R.A.M.C., is promoted to be Colonel, *vice* R. Townsend, promoted.

Colonel J. S. Wilkin, D.S.O., I.M.S., has been specially deputed to proceed to South Africa to supervise the Concentration Camps in the Transvaal and Orange River Colony.

Obituary.

Dr. G. E. C. Anderson.

An honourable career of great usefulness was brought to a close by the death at the Cape of Dr. G. E. C. Anderson. He passed through Guy's with great distinction, gaining the Michael Harris and year prizes, besides the Gold Medal and Exhibition for Anatomy, and was a First-class in the M.B., M.S., and M.D. He was a consulting surgeon to the Somerset Hospital and his judgment was very highly esteemed. In all things he was the good citizen, never shirking his responsibilities as a doctor or as a man, and his life, albeit short, was full of labour, and the position he held was in some measure his reward. He was a type of man that can least be spared.

Major S. O. Stuart, R.A.M.C.

A short official paragraph records the death from dysentery, at Winberg, of Major S. O. Stuart, R.A.M.C., who qualified from Guy's in 1881. His services were long and honourable. Like so many in the Army Medical he had borne the burden and heat of Empire, and served abroad in India and the Sudan, and a career of great promise, brightened by the prospect of his recent return to active work in South Africa, has been untimely cut short.

Passim.

Wide publication has been given in the press to a statement that under the Will of the late Mr. George King, of Eastbourne, the Hospital will receive £30,000. This statement like so many others of its class is incomplete and misleading. The facts are that the Hospital will at some future time, it may be twenty, thirty, or more years, come into possession of certain freehold ground rents producing £1100 per annum. The value of these ground rents would be probably nearer £25,000 than £30,000, but the point is of no consequence, for the conditions of the will are that the property may not be realised, but is to be held and retained by the Governors for the permanent benefit of the Hospital. This explanation does not in the least detract from the sterling worth of Mr. King's generous bequest, which we are informed by the authorities was arranged in that quiet and unostentatious spirit which has distinguished those from whom this Charity has received its largest measure of support.

We cordially agree with the wish of our correspondent concerning the South African Memorial Fund, viz., that a final decision should be arrived at when the meeting is held in May, and that a small committee should be elected to do that which they consider best with the funds. With a large committee or a general meeting there are so many schemes put forward, that unless one in particular meets with a very large amount of support, the discussion is likely to end where it commenced. It is a very difficult question to decide seeing that so many men have no definite views, and when any particular one is put before them adopt the attitude of the Irish emigrant to the Government, and are "agin it." Any suggestion put before the meeting should be practicable, for it is useless to suggest any scheme which is far beyond the means at disposal, so unless anyone has a definite plan which meets with support and can give some idea of the money required, it can hardly be definitely accepted. If this happens we quite agree with Dopper, that absolute power should be given to a small committee.

He also says that he favours the idea of an outdoor memorial but hopes a better site may be found for it. At a recent meeting of the Gazette Committee the outdoor scheme met with the approval of the majority present, but after considering the available spots where it should be put into effect decided on this particular spot chiefly by a process of elimination —the objections to the other spaces being so numerous that we cannot detail them. Dopper also expresses a fervent wish that the memorial should not be of a funereal character, and this is re-echoed by everybody. But does not he see that with the funds at disposal any such monument must be of quite small proportions and must fall into the hands of a variety of monumental mason and not into the hands of an artist who would erect something in good taste? Personally we think that the outdoor scheme is unsuitable for this very reason if for no other.

The alternative scheme of a memorial to be placed indoors, preferably in the Wills' library, has, we think, many things to be said in its favour. In the first place, it should be far more artistic, as practically the whole of the funds would be available for the memorial itself, and thus enable the work to be placed in good hands, while a considerable proportion would be absorbed in the out-door scheme by the foundations and base fit to bear anything that would be worthy of the object for which it is erected. In the second place, it would be more durable, and the inscription so necessary in things of this sort, would not be rapidly obliterated by the smoky air of these parts. There are many points to be considered in favour of both projects, and we can but hope with Dopper, that after due consideration, either at the meeting or by an elected committee something will be finally adopted, and that soon.

A circular-letter was sent round by the Gazette a few days ago to old Guy's men,

calling their attention to the South African Memorial scheme, and it has borne good fruit as may be seen by the subscription list which appears in our present issue. We are delighted that the appeal has met with such a response, and trust we shall be able to publish other lists of equal magnitude.

Contrary to the grumbles of the impatient "dresser for the week," whose professional zeal hoped much from the Final Tie at the Crystal Palace, and whose constant cry is that the cases are not so abundant as those in the good old days, the Annual Report for 1901, just published, shows that the accidents admitted were the third largest total for ten years. It had been accepted without enquiry that the opening of subways at the Bank, and the subterranean conveniences so prevalent nowadays, had greatly diminished the number of street accidents, and it is interesting to observe that this is not so.

The public patronage of the Front Surgery and Out-patients has not diminished but is increasing steadily, in spite of the necessity of waiting and the discouraging enquiries made as to their equitable claim to free attendance. Other points are that the cost per patient is increasing steadily but that their stay is shorter, so that if modern treatment is more expensive (?) we may say it is more efficacious—at least that is one way of putting it.

A point of some interest to the "youth who must be served" with Hospital appointment and College Fare, is that no less a sum than twelve hundred pounds is paid for the board of Resident medical officers. If this is entirely devoted to what are popularly known as the Residents, it suggests food for reflection in view of recent, and as yet, unremedied grumbles.

Without allowing for the number of meals that are skipped, and the generally incomplete attendance, it works out at over £80 a year for each resident, and considering that the careful middle class housekeeper reckons at most £40 a head for very much better food, it would seem that here there is at any rate an instance of value not received for money expended.

It has so often been quoted in the Gazette that one has got to ignore the great losses that agricultural depression has inflicted on a public, and till recently, a well endowed charity, but a glance at the income side of the account reveals the striking fact that the large agricultural holdings and the great endowments that made Guy's so prosperous in former years, produce a bare £23,000, less than half the expenditure last year—a striking and a notable fact. Another point of minor interest was that we looked in vain for the vivisection grant, though doubtless the eagle eye of the anti-monger will manage to unearth it.

Having regard to the present financial needs of the Hospital, it is more than a pity that although so near to the line of the Coronation Route, we possess no frontage which might be turned to advantage for the erection of stands. This, however, being the case, we are at liberty to invite support for one of our poorer neighbours. The ancient schools of St. George-the-Martyr, Southwark, are just about being transferred to a new site, and permission has been obtained to pull down the old buildings in time for a first-class covered stand to be erected. The site is a most excellent one, as the Borough Road is a spacious thoroughfare with broad pavements, and it is probable that the Procession will halt close by to enable His Majesty to receive an address from the Mayors of the South London Boroughs. The profits derived from the sale of seats will go directly towards the pressing needs of the these deserving schools, and as several Guy's people are interested in their welfare, we have pleasure in suggesting to any of our readers who may be on the look out for seats, that they will find here what they want. We understand that the prices range from £1 1s. to £6 6s., and seats may be booked on application to Mr. C. H. Wells, Guy's Hospital, who is Treasurer of the Schools.

The gathering of motor-cars at the Agricultural Hall was not advertised with the same flourish of trumpets that is familiar; but perhaps the actual advance in motor construction is none the less remarkable. Around the hall, in every shape of size and ugliness, the

motors were arranged, most bearing labels of "Sold." It was interesting to note the great appeals to doctors to buy motors; and it is certainly true that to doctors, almost alone of educated professions, will the motor car, when perfected, prove a boon.

The prices were somewhat modestly kept in the background, but it is quite plain that for the motor industry to gain much from the medical profession the high prices must be regulated. It seems that the motor industry has nothing to learn from the cycle boom and collapse, and that instead of appealing to the less wealthy masses, they prefer to try and extort enormous profit from the ranks of the plutocracy.

We should be glad to publish an article on the relative cost and risk of breakdown to which doctors who rely on motors are liable, as it is a subject of much enquiry, and it is to be hoped that the great cost of country practices may yet be brought down to some more reasonable proportion.

In the current number of the *Hospital* is an account of our new Nurses' Home, and an illustration of it as it will appear when its disfiguring surroundings are removed. It is all very charming and the writer grows quite enthusiastic, but we must take exception to his remarks concerning the dining hall and its gallery. From this we gather that it is a spot from whence the visitor can gaze unseen upon the nurses at their meals. This is, of course, permissible, and possibly courted at a great function like a City dinner, but as an everyday occurrence it would be extremely monotonous and not at all desirable. From the same source we learn that the swimming bath is to be reserved on three days in the week for men. Great interest is now displayed in the Home and the bath in particular now that the summer season is approaching.

The number of swimming men in the Hospital is large, and if everybody is allowed the use of the bath at one time it will contain considerably more men then water, but no doubt suitable rules will be arranged. The use of the bath might well be reserved for residents in the College, not actually the Resident Staff, during certain hours on the days set apart for men, and we would suggest that the Swimming Club would be much benefited by having a claim on the bath for a short time for the practice of water polo, and our chances of winning the Inter-Hospital Cup be considerably improved.

Illness has made itself more felt than usual during the past few weeks, Sister Isolation being the last, she now being ill with diphtheria. We are extremely sorry to hear that Mr. Wylie is suffering from complications following his attack of scarlet fever. Mr. Adams is also down with the same complaint. We sincerely hope that they will all shortly be back amongst us again.

The close of the Winter Session and the advent of the easiest term at Guy's as at the Universities, has not been marked as in former years by the Annual Ladies' Night of the Debating Society. Why this is so we know not, but 'tis a pity. The society the last four years has been phenomenally prosperous and popular, and the audiences have always been good, though curiously the Ladies' night has never been up to the ordinary occasion. It may have been the restraint, more perhaps the isolating of members, partly the unfamiliar surroundings, but most of all we fancy the general attempt at humour, often too obviously forced. Be this as it may, we miss the function and regret its disappearance, as it does not (we speak under correction) betoken abundant energy in the society.

The Cricket season is upon us and the ground is already almost ready, under the careful attention of Harris. The victorious eleven of last summer are mostly available, and with the enthusiasm that marked last season's beginning, we hope the record will be as good. It must be a long time since two such extremely powerful teams secured the Cricket and the Rugger Cup; but reliance on the past is fatal to the future; so that we hope no stone will be left unturned to give the Smoking-room for next year the same replenished appearance that it now enjoys.

South African Memorial Fund.

EIGHTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	139	2	6
P. H. Pye-Smith, M.D.	5	5	0
H. Airy, M.D.	2	2	0
J. G. Swayne, M.D.	2	2	0
J. H. Badcock	1	1	0
S. E. Denyer, M.B., C.M.G.	1	1	0
J. H. Galton, M.D.	1	1	0
R. Howard, M.B.	1	1	0
Ed. H. Lushington	1	1	0
E. May, M.D.	1	1	0
James A. Rigby, M.D.	1	1	0
Sir Samuel Wilks, Bart., M.D.	1	1	0
A. P. Allan, M.D.	0	10	6
T. Reuell Atkinson, M.D.	0	10	6
P. C. P. Ingram	0	10	6
A. H. B. Kirkman	0	10	6
E. H. Lipscomb, M.B.	0	10	6
Miss L. G. Moberly	0	10	6
Thomas Eastes, M.D.	0	10	0
A. Gillingham	0	10	0
Bournemouth	0	5	0
A. J. Collis, M.D.	0	5	0
J. N. Gardiner, M.B.	0	2	6
	£161	15	0

Reviews.

The price of books submitted for review should in every case be stated.

Illustrated Medical Dictionary. By W. A. Newman Dorland, M.B. (W. B. Saunders & Co.) 12s. 6d.

This book which has been described as a "Concise and convenient word-book," strikes the mean between an ordinary dictionary and the larger encyclopedias, for though in some cases nothing further than the definition and derivation of a word is given, whenever necessary the description is enlarged to a fairly complete account, thus the source, doses, and some of the preparations of drugs are given.

In addition to this there are several very useful tables of tests, stains, methods of treatment, etc. The illustrations are an especial feature of the work, many of the plates being carefully coloured.

Though somewhat of a luxury, such a book of reference is always a valuable addition to a doctor's library.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

The Removal of the Dental Pulp.

A paper read before the Dental Society on January 10th, by Mr. E. Field Deck.

Mr. President and Gentlemen,—In the choice of a subject upon which to address you this afternoon, I have deemed it advisable to select a practical one—one that we are constantly having to deal with in our daily work, viz., the removal of the dental pulp; and I trust that in its discussion we may gather some new and useful ideas from one another.

I think we need not go over the ground of the anatomy of this organ, though a good knowledge of the forms and shapes of the teeth and roots is an essential for intelligent work. Get rid of the idea, and make your patients do likewise, that it is "only a nerve!" It has a temperature sense, but no tactile sense; it cannot distinguish between heat and cold.

Now, when and why is the pulp removed from a tooth? Broadly considered, whenever there is a tendency on the part of the pulp for self-destruction, it is a therapeutic measure to anticipate this end, and its accompanying dangers, by removing it. In constructive diseases of the pulp, such as the formation of pulp nodules and calcareous degeneration of the pulp, it is necessary to remove this organ to relieve the severe neuralgia usually associated with such conditions. It is sometimes judicious to remove the pulp in cases where individual teeth are attacked with pyorrhea alveolaris, the object being to divert the blood usually going to the pulp into the arterioles of the pericementum.

Again, we frequently need to extirpate the pulps of healthy teeth where, from unsightliness or other cause, an anterior tooth needs crowning, or where a vital tooth is needed for the support of a bridge.

One cannot but be impressed with the variety of methods that have been, and are still in use for the removal of the pulp, and which vary markedly in merit; and it is my purpose to describe some of the methods in common practice to-day; but before doing so, we must recognise, as essential to a satisfactory result, the following general requirements for any method:—

(*a*) That the operation be as nearly painless as possible.
(*b*) That the removal of the pulp be quickly effected.
(*c*) That due care be taken to prevent subsequent staining of the dentin.

Roughly considered, there are two general methods of procedure:—

(1) By the slow action of chemical agents, bringing about devitalisation of the pulp tissues.
(2) By the use of such agents as place the pulp in a state of anæsthesia.

Belonging to the former class are arsenic trioxide, cobalt, zinc chloride, chromic acid, potassium hydrate, carbolic and trichloracetic acid. To the latter, such drugs as cocaine hydrochlorate, eucaine, vapocaine, carbolic acid,

and chloroform. Let us first consider arsenic trioxide, or arsenious acid. Arsenic, associated with other drugs to render the devitalizing process as painless as possible, is probably used more than any other agent for pulp removal.

You are all familiar with the various formulæ of Arsenic, combined with Morphia, Cocaine, Carbolic Acid, Oil of Cloves, etc., which are given in all the text-books, so we will not discuss their composition.

There is no doubt as to the efficacy of arsenic, but there is considerable doubt in regard to the method of application, the time the application should be allowed to remain, and dependent upon the latter the exact limits of the destructive power of this drug. We are taught by some that it is necessary to have an exposure, by others that it will accomplish our purpose through a layer of dentine by way of the dental tubules; in fact, some men advise drilling a special hole for its reception when there is difficulty in making application in the cavity of exposure.

Arsenic should never be used upon an inflamed pulp, because while in this state of hyperæsthesia it resists the absorption of the arsenic. To relieve the congestion, swab out the cavity with a 5 per cent. solution of Formalin, and seal in a dressing of Tannic Acid and Oil of Cassia for a few days, or Thymol and Cocaine made into a paste with glycerine.

In making the arsenical application, you all know that it requires the minutest amount of arsenic to effect our purpose, varying according to the tooth from $\frac{1}{100}$ to $\frac{1}{25}$ grain. It is best used upon cotton in the form of fibre. In sealing avoid cotton and the varnishes, and use temporary stopping, or better still, oxyphosphate cement, avoiding any pressure upon the pulp.

How long should an arsenical application be allowed to remain? Well, this of course depends upon the amount used, and the resistance to absorption displayed by the pulp tissue. Usually, however, there is complete death of the organ in from two to three days. Some operators leave the arsenic in for much longer periods, until, in fact, there is sloughing of the pulp tissue from its attachments. It is just here, however, that I think there is a danger. May it not be that many of the pericemental disturbances associated with pulpless teeth—many of the so-called "lame teeth,"—are traceable to the practice of allowing arsenic to remain in a tooth for too long a period?

The late Dr. Burchard, in his work on Dental Pathology and Therapeutics, says in regard to the action of arsenic:—"The indication is, therefore, that a minute portion of the arsenic is taken into the pulp; this may be either through the odontoblastic processes in cases of non-exposed pulps, or, when exposed, by the cells themselves, and causes violent reaction of the vessel-walls, which dilate to their utmost; extravasation of corpuscles occurs and circulation is checked at the end of the root, the pulp-vessels are mechanically occluded, so that no absorbed arsenic is carried beyond the pulp extremity. The arsenic exercises its paralyzant and degenerative influence upon the nerves of the pulp, after first inducing a violent irritation, which may be due to the specific action of arsenic upon the nerves, or to the intense hyperæmia. The strangulation theory cannot, however, hold in all cases; for progressive death of structures free to expand, occurs after applications of arsenic, so that the specific and gradual action of the poison must be the important factor. Strangulation would imply an always sudden death of the pulp *en masse*, which evidently does not always occur, for complete death of the organ may be gradual and require several days. In other cases, repeated applications may be necessary."

I do not think it is an established fact that the action of this drug is really blocked by this barrier at the apex. I imagine it is not so. Then again, may not the dentine be so thoroughly impressed with this drug, *viâ* the dental tubules, that the canaliculi and lacunæ of the cementum are also involved, with the result that the cementum may die?

Dr. E. C. Kirk ("Dental Cosmos," August, 1898), says:—"Broadly considered, any inflammatory action is a disturbance of the normal processes of nutrition, and this is true both of general and local inflammations, the disturbance being proportioned to the intensity of the irritative action. Where bacteria and their products are the excitants of the inflammation, their effective invasion is conditional upon the vital status of the tissue concerned. If the vital resistance of the tissue is sufficiently high it becomes immune, and bacterial invasion is impossible. The vital potential of a tissue is the result of the sum total of its nutritive processes normally performed. Any interference with the normal nutritive process, therefore, results in a diminution of the vital potential of a tissue, and renders it liable to an invasion by bacteria, with consequent inflammatory reaction. A disturbance of normal nutrition, resulting in lowered vital resistance is, therefore, a precedent condition to effective bacterial invasion."

Hence, is it not quite likely, that the vitality of the tissues in the apical region of the pericementum is prejudiced unfavourably by the unconfined action of the arsenic? With the result that whenever the general health of the patient is below normal, there is a likelihood of this region becoming the focus of an acute inflammation lighted up by infection carried in the general circulation. So that it would seem advisable to see our patients and effect the removal of the pulp where we have used arsenic, before the devitalization has reached the extreme end of the root.

Before passing on to the discussion of other methods, let us remember that arsenic sometimes produces so much irritation of the pulp, that the violent congestion which follows, occasions disorganization of the red blood corpuscles. The hæmatin in the latter is set free, with the result that the dentine is discoloured, assuming a pinkish hue, which later turns brown, and finally black. This is most likely to occur when precautions have not been taken to subdue the congestion of the pulp, previous to applying the arsenic. Should this unfortunate condition

obtain, we shall have to resort to a series of bleaching operations, which will be vexatious to the patient and operator alike.

Although we cannot in all cases afford to disregard the use of arsenic, still there are various other means we can have recourse to, some of which I consider have distinct advantages.

The use of such agents as Zinc Chloride, Chromic Acid, Potassium Hydrate, etc., is not much practised because of their slow action, and not infrequently their use is followed by violent paroxysms of pain. Cobalt has been preferred by some practitioners, but it is very similar in its action to arsenic, depending in fact for its specific action upon the presence of the latter in its composition.

Let us now consider a method introduced within recent years known as "Pressure Anæsthesia," and which has to a large extent superseded the use of Arsenic Trioxide. It is particularly applicable to the single-rooted teeth, but with care and patience can be used with great success in the multi-rooted teeth. Taking an anterior tooth for example the method is as follows:—The first thing to be done, as in all operations where the canals of teeth are involved, is to isolate the tooth with the rubber-dam; then wipe the tooth carefully with a swab of cotton dipped in absolute alcohol, to remove mucus and bacterial forms as far as possible from the field of operation. Wash out any existing cavity with warm water, and remove all decomposed dentine.

If the pulp is not already exposed, the pain of making an exposure may be deadened by the use of a suitable obtundent: Ethyl Chloride answers well. As soon as we have made the pulp bleed, we may make our application of cocaine hydrochlorate.

Previous to making the application, however, all instruments for the removal of the pulp should be in readiness, plenty of broaches and sharp burs, a round bur of suitable size being inserted in the engine hand-piece.

Now that all is ready, take a small piece of amadou, dip in absolute alcohol, and allow it to become saturated with powdered cocaine hydrochlorate crystals. *Carefully lay this over the exposure, cut a piece* of unvulcanized red rubber to roughly fit the cavity; place this over the amadou, and with a large ball burnisher exert pressure upon the rubber in the direction of the pulp. The pressure should be light at first, just enough to elicit a response, which can be detected by watching the patient's eyes. After the lapse of about fifteen seconds, the pressure may be gradually increased as the cocain anæsthetizes the pulp. Continue this pressure for two or three minutes, at the end of which time the pulp may usually be removed painlessly. *Having removed the rubber and amadou, and* with the engine running rapidly, open up the pulp chamber and establish free entrance to the canal. Remove the débris with hydrogen dioxide, and then pass a sterile broach up the canal, entangle the pulp and remove. It will be noticed that it is colourless. In molar teeth it is sometimes necessary to make a second application of cocaine for the roots, after the removal of the coronal portion of the pulp.

There is usually a profuse hæmorrhage at the apex where the pulp has been severed. It is well to allow the bleeding to continue for a few minutes, and thus relieve any congestion present; then wash out the cavity and canal with applications of hydrogen dioxide, which acts both as a cleanser and as a hæmostatic. If difficulty is experienced in checking the hæmorrhage other agents may be used carried up the canal upon a point of bibulous paper, bichloride of mercury, campho-phenique, carbolic acid, and hamamelis being recommended, as also is a ten per cent. or fifteen per cent. solution of trichloracetic acid. When the bleeding has ceased, swab the canals again with hydrogen dioxide, and then dry it thoroughly, by means of alcohol and hot air syringe. Some men advise immediate root filling, but if the patient can be seen again it is safer to make a temporary dressing of any non-irritating antiseptic, such as campho-phenique, oil of cassia, or hydronaphol solution. After the lapse of a few days, fill the canal with gutta percha points, having previously moistened it with either oil of cajeput or eucalyptus. Or after closing the apex of canal with a small piece of gutta percha, the remainder of the canal may be filled with cotton and oxychloride cement.

Instead of using the fresh cocaine crystals in the way I have described, some operators keep a stock solution, composed of Cocaine Hydrochlorate in Alcohol, five parts, and Formalin one part, which is applied upon a piece of amadou, and unvulcanized rubber is used in the same way as above.

Cocaine and Eucaine have also been used with the electric current, for painless removal of the pulp, but owing to the complicated nature of the cataphoric outfits needed, and the not infrequent comparatively long time necessary for complete anæsthesia of the pulp, this method has not been adopted very extensively.

Dr. E. T. Darby, of Philadelphia, uses the following method:—An all glass hypodermic syringe is filled with a solution of equal parts of Carbolic Acid and Chloroform. The canula, the only metal part of the syringe used, is placed in contact with the pulp, and held there by packing gutta percha around its point. The syringe is then attached to the canula, and gentle pressure exerted for from three to five minutes; at the end of this time the pulp may be extracted painlessly. Whenever a tooth with a living pulp is to be cut off, for the purpose of fitting a crown upon the root, advantage may be taken of the temporary shock the pulp suffers, after the crown portion is broken off, with excising forceps, to quickly drive a sharp wooden peg up the canal. This may be done with little or no pain, and the pulp tissue may then be removed with the Donaldson broach. Pulps are sometimes removed through the agency of Ethyl Chloride, or while the patient is under Nitrous-oxide Gas or Chloroform.

With regard to pulp nodules, the treatment of course is the removal of the pulp. Dr. Burchard advises the

use of arsenic and cocaine for the purpose, but the first application should contain a great deal more cocaine than arsenic. In forty-eight hours a stronger paste may be used. In some cases it may be two or three weeks before devitalization is complete. I think cocaine and pressure would be a speedier method in these cases, but I have never had a case of pulp nodules to test it upon.

Devitalization of the deciduous teeth, calls for somewhat special treatment. Whenever the pulp of a deciduous tooth has ached, it is best to destroy it, but not while it is still aching. Very strong iodine applied to a pulp will destroy it, or we may use trichloracetic acid. The latter not only cauterizes the pulp, but it also tans it. It is excellent for applying to fungous growths of the pulp. Take it in crystal form, and add about 10 per cent. water. This makes a powerful styptic. The application of all strong escharotics to the pulp, should be preceded by the use of cocaine solution. A canal filling for the deciduous teeth should not in itself be a mechanical irritant, and so interfere in the absorption of the root.

Thymol, salol or paraffin may be used to advantage. Pulps of teeth which are already partially dead, call for especial care in treatment. Carelessness may result in an acute abscess of the apex, which in turn might result in pyæmia, in patients of poor vitality.

Such teeth should be first isolated with the rubber dam, and then the cavity flooded with a strong solution of lysol. Working through this lysol the canals may be gradually entered, and cleansed with the barbed broaches.

The canals of many teeth may be conveniently enlarged by means of 40 per cent. sulphuric acid, carried up the canal as far as possible upon a broach and cotton. A fine smooth broach may then be patiently worked up and down the canals. This will soon enlarge them, when the acid should be neutralised with bi-carbonate of soda.

Formalin, 2 per cent. solution, is very useful for dressing canals which have been septic previous to filling. However, the subject of root medication and filling is too vast to be treated in this paper. Pulp mummification, pulp-digestion, and immediate root filling are all allied subjects of the greatest interest; but time and the length of this paper will not allow of their discussion.

Papers by Guy's Men.

Goulstonian Lectures on Some Abnormal Psychical Conditions in Children. By George F. Still, M.A., M.D. Cantab., F.R.C.P. Lond.—*The Lancet*, 12th and 19th April.

A Case of Purulent Peritonitis associated with Empyema: Recovery. By Henry Ashby, M.D., F.R.C.P. Lond.—*Lancet*, 19th April.

On Inlays. By H. A. E. Canning, L.D.S. Eng.—*Journal of the British Dental Association*, for April.

Types.

IX.—The "Pro."

From reasons varied, from motives deep, from necessity some, from fantasy others, every year sees the advent of a large and heterogeneous collection of would-be ministering angels, as ardent as they are ignorant, and as indolent as they are healthy.

Passing the formidable ordeal of the Matron's inspection and much reference to spiritual pastors, and recommendations from worldly masters, armed in innocence and clothed by the hospital in an ill-fitting, ready-made uniform, they enter their varied wards in a state of mind in which misty visions of "man's guardian angel" and "succour to the distressed and dying" are so delightfully intertwined with the novelty of a picnic and the dignity of a devotee, that the beauty of the ideal obscures the more prosaic nature of the reality.

By this step, as in all real occupations, the link in the family circle is severed, for them the suburban social fabric is undone, lovers are left, friendship abandoned, and acquaintances forgotten, and all alike, the rich and the poor, the fair and the dark, the vivacious and the moody, the earnest and intense with the flippant followers of fickle fashions, the tenants of castle, mansion, vicarage, and cottage swell the seething throng, of which each is now but a self-centred unit in a fortuitous concourse. It is at first a chaos, it will be a cosmos.

The determining causes are as varied as they are obscure. Some social failures balance some self-veiled nuns, beloved and regretted of their hearth and home; some daring explorers wearying of the hollowness and emptiness of indolent and aimless ease, and every variety of birth and breeding jostles among every opposite type and lineage and descent.

In the modern convent the discipline is severe and wholesome, but the life is hard and healthy. As the budding Pro., garbed in severe yet tasty dress, cleans the brass and dusts the cots, the awful responsibility of her position, with lives trembling in the balance and the cat purring on the hearth-rug (and occasionally a snake), overwhelms her with fear, and the fetching of clean

water and bowls, and even a feeding cup for the Staff nurse, is invested with an awful solemnity, so fearsome a thing it is to tread the "stricken field."

She hardly dares to smile (the Sister sees to that), and in the presence of her ancient ally—man—she maintains a provoking, albeit alluring, reticence and discretion.

At last the chance dusting of the ferns or the wearing of a red flower draws the attention of the tuft-hunter who tenderly enquires if she is an L.P.

By this time she is lucky if she has escaped the discovery that "man's inhumanity to man" is as nothing compared with a woman's nagging, and that absolute authority, like Ulysses' bow, is wielded aright by few.

In those that survive the traces of the fiery trial are as striking as they are welcome. To indolence and self consideration succeed desire for approval and pride in work, and the immense difference is appreciated alike by the cruel "tyrant sister who have the corps at heart," and the workers in the ward.

Widened in ideas and flattened in the feet, the outlines of life's grim tragedy are dimly discerned, which hitherto veiled in obscurity and bound in morocco, have reposed in state on drawing-room tables with the sordid points slurred and the romance intensified.

In her well-ordered life incidents are epochs and trivialities engrossing. In the forenoon the untidy screen or "unstowed" dressing provokes the voice of authority; but the afternoon shews unashamed a screen encampment, behind whose seclusion the dyspeptic tea, toast, and slop, is flavoured with scandal and "shop."

Neat and healthy, the close of "pro."-dom leaves her as popular with her patients as with the sisters, strong, intelligent and responsible.

She has visited the Conservation Room to have her teeth tinkered, and the "Consoling Room" to have her soul softened. Like Ulysses she has seen many wards and men, and suffered much, she is familiar with Mary, the Out-patients, and the Dispensary. She has learnt the art of tea-drinking and of brewing bread and milk, and the foibles of humanity from the toast and hot bottle of the sister, the bread and milk and cocoa of the mere man to the hot drinks of the patients and the flowers for the ward-maid, and she manages with equal dexterity the rudeness of the dresser, the crass obstinacy of the H.-S., the whining of the children, and the fancies of the sick and the worries of the relatives.

She has, if unlucky, been a special on a "Trachy" before she knew Wells' forceps from dilators, and has languished in the unsympathetic sick-room, been called "My dear" by a most pressing surgeon, felt the joys of incisions and drainage, had her blood counted and been suspected of neurosis and "browsing."

Fixed but unformulated are her conclusions.

If browsing is the relaxation of choice, the church by tradition and consent, is entirely devoid of suspicion.

The Sister who browsed knows the ropes, and the greater the browser as a nurse the more vigilant and suspicious as a Sister.

In the dormitory "tired nature's sweet restorer" is tempered by exuberant spirits, but woe betide the "fag" who wanders down the Senior's "alley," and steals her bath.

The official "hours off" vary in length with the decency of the Sister.

There are more ways of entering a cubicle than one, and more keys than the Matron's.

The lonely(?) night duty is pleasanter than the thronging day. Engagement rings, high heels, running and ornaments do not suit a convert.

Dover's powder helps sleep but the heat is unbecoming and unpleasant. A popular nurse means a free dispensary.

Liberty to wear outdoor dress is a boomerang, it frequently hurts those who least expect it.

Beware of too friendly a Resident, presently the Head Nurse will speak or weep, perhaps both, either is unpleasant. Beware of the young and frivolous Sister, they are "gey ill" to work under. The Sister may browse but the Pro. may not look over the screen. A "Consoling Room" is a concession, but the novelty wears off.

Happy and autograph-hunting the finished Pro. anxiously awaits a summons, and, trying on strings, furtively wonders if Mary, Martha or the Eye Wards will next be vacant.

THE HAWK.

Correspondence.

To the Editor of Guy's Hospital Gazette.

South African Memorial.

Sir,—I see from a recent Gazette that of the many suggestions that have been made with regard to the South African Memorial that two have been seriously discussed, viz., an indoor memorial, probably a tablet of sorts, to be placed in the new Wills' Library, or some sort of monument outdoors on the grass plot next to Maze Pond.

It is high time that something is decided, for if the final arrangement is delayed much longer, I am afraid that interest in the scheme will lag. Personally, I think that an outdoor memorial would be more suitable, but could not a better site be arranged for than the one already suggested? Of course I am aware that the final decision must largely rest on the amount of funds that are at disposal, but whatever scheme is accepted, I trust that nothing which is in any way funereal will be considered. As a general meeting is to be held, might I suggest that a small committee should be elected with absolute power, as that would be by far the best means of effecting a settlement.—Yours,

DOPPER.

Dear Sir,—I beg to thank you for the information you have sent me in relation to the raising a subscription for a memorial to those Guy's men who have fallen in South Africa, and would suggest that it be placed on the grass plot near to Hunt's House; and enclose a cheque for one guinea.—I am, dear sir, yours truly,

E. MAY, M.D.

Queen's Road, Broadstairs,
23rd April, 1902.

Fives' Court.

Dear Sir,—I should be glad if you would allow me to encroach upon your valuable space in drawing attention to the present condition of the Fives' Court. This is, I may say, a very bad one. I do not think in the memory of any one at present at the hospital has anything been done to keep the Court in good repair. It is chiefly on behalf of the Residents that I write. For them there is no other means of getting sufficient exercise, when confined to the hospital, than by playing fives. And in the present state of the floor, a good game is often spoilt by the irregularities of the floor. Besides which puddles of water collect and remain for many hours after the rest of the Court is dry.

I would suggest that a new layer of cement be laid down, and the holes in the front wall patched up; also that some more wire netting be put along the left hand and back walls to prevent balls going over so frequently.

In writing this letter I feel I am expressing the wish of a good many men living in the College, and that these inexpensive repairs would be a popular blessing.—Yours sincerely,

RICHARD S. ROPER.

Guy's Hospital, S.E.,
April 21st, 1902.

Dear Sir,—I am not a member of the Alpine Club (neither do I play Ping Pong in the Gymnasium), but I heard recently that there was a Squash Racquets' Court in some remote corner of the hospital *demesne*. I am an enthusiast. I can play squash racquets almost anywhere—my most intimate friends deny this absolutely; but on the hospital Court—no, Sir! Even I, with the simple cunning God has given me, am lost—quite lost.

The Green Book allures the unsuspecting talent of the rising generation to Guy's, chiefly by the eloquence of its description of the Racquets' Court; he comes—he sees—he is conquered—he cannot find it. What he does find is a place that once was square, four walls that once were thought to be perpendicular, and a floor that in prehistoric times may have been horizontal. This is by the way. To proceed with my own experiences. I got wind of the existence of the court. By the aid of the North Star I tracked down a winding cinder path, I fell through a ponderous door, and was at once lost on a kopje. I was evidently upon the site of the famous court, for here and there I broke my ankle against a knob of concrete. A yawning crevasse intercepted my progress across the ancient floor, and I fell upon the front of my back and peered down into the abyss. Far below, I could dimly discern a brace or two of mouldering squash balls, and the petrified rim of an old racquet. Here then the contests between the gods must have taken place; upon this very spot those herculean contests must have raged, which egged on the compiler of the Green Book to so much eloquence. Giddy and dazed from peering into such depths, I rolled myself over; towering above me, I descried a rocky pinnacle, it may have been snow-capped, I cannot say; at all events it disappeared into the smoke. I *thought* I saw the Oof-bird nesting upon it, but that may have been only a pigeon on the neighbouring hotel, I do not know. I turned away amazed at the idea that within so short a time this rocky land has evolved out of what history proclaims to have been once a level concrete quadrangle.

I must apologise, dear Sir, for having thus trespassed upon your valuable space, but it has occurred to me that this phenomena is worth recording. How happy must those days have been when there really *was* a level racquet court. Alas!—Believe me, yours truly,

SQUASH.

Nursing News.

Matron's Office.

Nurse E. M. Thompson left the Hospital on completion of her three years' training on March 29th, to take up the appointment of Sister at the Royal Portsmouth Hospital. Probationer P. Manning has been appointed to succeed Nurse Thompson as Head Nurse in Bright ward.

Nurse E. M. Ball, Head Nurse in Martha ward, left the Hospital on completion of her training, to take up her duties on the Private Nursing Staff. Probationer A. Wood has been appointed to succeed her as Head Nurse.

Nurse Minshall Head Nurse in Patience ward, left the Hospital on completion of her training on April 1st, to take up the appointment of Charge Nurse at the Scarborough Sea Bathing Infirmary.

Nurse M. Palmer, Head Nurse in Ruth, who completed her training in December last, left the Hospital on April 3rd.

Nurse Davison, who completed her training in February last, has been appointed Charge Nurse at the Sea Bathing Infirmary, Scarborough, and left the Hospital on April 10th, to take up her new duties.

An April 12th, Nurse Whittingham was transferred to the Theatre, and Probationer Iszard was appointed to succeed her as Head Nurse in Mary ward.

Nurse Baynes Reed, Head Nurse in Victoria, was transferred to Naaman ward as Head Nurse on April 15th.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

H., Reigate.—This is a soft carcinoma of the breast and the spaces containing the cancerous cells are large. Much of the tissue is undergoing caseous degeneration. The growth is evidently of *short* duration, probably only a few months.

PATHOLOGIST.

Sport.

Association Football.

2nd ELEVEN.—REPORT OF SEASON.

Although this has been a most successful season, nevertheless it has in many ways been rather a slack one.

At the commencement of the season some good teams were got together, in spite of too frequent scratchings, and an uninterrupted line of victories was recorded as far as the fourth round of the Junior Surrey Cup, in which Lorn brought about our downfall.

Soon after this the Captain was removed to a higher sphere by the selection committee of the 1st. In the Inter-Hospital Cup Competition, however, a better fate awaited us, as, after playing through every round, we met and defeated London, the holders. Since during the season only two matches have been lost, we may reasonably hope to have a stronger fixture list for next season.

Birth.

BIDDLE.—On April 12th, at 6, Chandos Place, Broadstairs, the wife of Henry G. Biddle, M.R.C.S. Eng., L.R.C.P., of a daughter.

Marriages.

DE MIERRE—HOLMAN.—On April 9th, at East Hoathly Church, by the Rev. H. Harbord, rector, assisted by the Rev. J. L. Brock, curate, Albert de Mierre, Seaside Road, Eastbourne, to Gertrude Elizabeth Meade, daughter of Henry Colgate Holman. Lydfords, East Hoathly, Sussex.

HENRY—FARR.—On the 5th April, at Immanuel Church, Streatham Common, by the Rev. H. F. S. Adams, vicar, George Nicol Henry, M.B., fourth son of the late Andrew Henry, of Macduff, N.B., to Mary Louise, youngest daughter of the late Dr. George Frederick Farr, of Kennington and East Twickenham, and Mrs. Farr, of Oakdale Road, Streatham.

Deaths.

ANDERSON.—On March 27th, at Cape Town, South Africa, George Elliott Caldwell Anderson, M.D., B.S. Lond., Consulting Surgeon, New Somerset Hospital, Cape Town.

CHILTON.—On April 2nd, at Bristol, Reginald Horace Chilton, M.R.C.S., L.R.C.P. Lond., aged 31 years.

STUART.—On April 18th, at Winberg, South Africa, of dysentery, Sidney Offord Stuart, F.R.C.S., Major R.A.M.C., the dearly loved younger son of the late I. O. Stuart, of 30, The Common, Woolwich.

Ed.—D. G. G.

Contents.

	PAGE
HOSPITAL NURSING	185–186
PROPTOSIS: Clinical Lecture by Mr. Higgens	186–193
PAPERS BY GUY'S MEN	193
CASE OF DIAPHRAGMATIC AND VAGUS PARALYSIS AFTER DIPHTHERIA—DEATH	194
PASS LIST	194–195
SPORT: Association Football—1st XI.—Account of Season	195
CORRESPONDENCE: South African Memorial	196
SOUTH AFRICAN MEMORIAL FUND; Ninth Subscription List	196
PASSIM	197–198
GUY'S DENTAL TRAVELLING SCHOLARSHIP	198
TRAUMATIC FEVER: By P. N. Blake Odgers, B.A	199–208
REVIEWS	208
APPOINTMENTS	208

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

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The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

May, 1902.

Sat. 10.—Messrs. Golding-Bird and Dunn's take-in; Drs., E. N. Jupp and C. M. Anthony; Cl., W. H. Bowen.
G.H.C.C., I., v. Beckenham, away.
II., v. Old Charlton, away.
III., v. Enfield Lock, away.
G.H.L.T.C., v. Kent, home.

Wed. 14.—G.H.C.C., I., v. Blue Mantles, away.
II., v. London Hospital "A," away.

Thur. 15.—Messrs. Jacobson and Fripp's take-in; Drs., D. R. Pike and A. R. Brailey; Cl., H. W. Brown.

Sat. 17.—G.H.C.C., I., v. Surbiton, away.
II., v. R.I.E.C. "A," home.
III., v. Camberwell House, away.
G.H.L.T.C., Blackheath "A," home.

Mon. 19.—Whit Monday.
Medical School Office closed.

Wed. 21.—G.H.C.C., II., v. Thespids, home.

Thur. 22.—Messrs. Symond's and Steward's take-in; Drs., H. E. Morris and W. H. Bent; Cl., W. G. Parker.

Sat. 24.—G.H.C.C., III., v. Christchurch Institute "A," away.

Guy's Hospital Gazette.

MAY 10, 1902.

Hospital Nursing.

WE do not remember ever having seen a more mischievous and rambling tirade in a well-known contemporary than the "Case against Hospital Nurses" in the *Nineteenth Century*. It was in the full expectation that a dignified, well-merited and severe rejoinder would dispose of an unpleasant episode that we awaited the next number, but good though the articles are, they seem to us to "suffer fools gladly," relying on their own wisdom and to reason where reason is useless. It is incumbent, if unpleasant, to express plainly our feelings on the subject.

The indictment is as black as it is rambling, the facts are as false as they are scattered, and the real intention or meaning is as obscure as the sentiments are ridiculous.

The picture drawn, to sum it up, is briefly: That the nurses are drawn from all classes; that fifty per cent. fail to complete their training, which is bad owing to the Sisters and Matrons leaving much to be desired; their enthusiasm is reduced by continual snubbing till it vanishes; petty tyrannies break their spirit; their hours are so long, their duty so engrossing, that their intellects are so cramped and their bodies so fatigued that shop is their only talk, and brutality, callousness, and irreverence at deathbeds the inevitable result.

Could anything be more untrue, or display more fatuous ignorance, or be more dangerous?

Is the writer aware that the breakdown ratio is very low, that the experience shows that the health of the nurses is, as a rule, greatly improved; has she ever seen these poor unfortunates as the inmates of a great hospital see them?

To those who know, the devotion of Sisters and nurses, as a whole (and as a whole they must be acquitted or condemned), is as obvious as the respect and affection of their patients is open and notable. It is almost irreverent when thinking of the dying scenes so reverently and kindly tended to speak of callous disrespect of the dead. All know this, at least, to be false, and

none more than the poor--best judges of true kindliness and humanity. Widely different are the facts.

The demand for the nurse exceeds the supply and the demand is, in countless cases, limited only by the purse. The popularity of the nurses in their patients' homes is proverbial, and their sphere of activity widens every year.

It were idle to point out the multitudinous contradictions, the obvious fallacies, the points that betray a very superficial knowledge of nursing as we know it, and a still slighter appreciation of the difficulties so lightly passed over.

But it is perhaps superfluous to point out the lesson that educated readers can so easily draw, but the cloven hoof shows through in a quotation from *The Humanitarian*. At times the writer advocates a strike on behalf of the nurses, at times condemns them root and hand, and elsewhere acknowledges they are good material to have.

The emanation in reality proceeds from that large and heterogenous class that tirades with equal and ill-directed vigour against some or all of the deductions from experience or settled opinions of mankind. It is Hall Caine's nurse Glory who is exalted at the expense of her more practical, if less sentimental, sister. It is the gushing amateur, whom sentiment and fad have ill-guided into medicine, with whom the writer has most sympathy.

In truth, the writer is but the mouth-piece (an elegant and smooth mouth-piece withal) of a class noted for the hysterical sympathy which at times leads emotional people to exploit the doctor's profession, the nurse's profession, and to rush boldly into controversies with fixed but fatuous self-conceit. That is the source of such articles as these, whose ignorance of the subject is only equalled by the extent of the mischief they cause among the undiscerning general public.

It is absolutely extraordinary, to put it mildly, to see a further special attack on the surgical nurses for their rigid adherence to medical instructions, and to find that the writer, whilst admitting that the great success of surgical operations is in no small measure due to the keen professional interest nurses take in their patients as "cases," yet goes on to draw the following astounding conclusion, that "this is hardly a comforting reflection for the general public *who may some unhappy day have to have their lives saved for them* by the 'stars' of the profession."

After a sentiment like this, it matters little that the article is in the main untrue and entirely unfair, and that, if taken serious, it is as cruel as it is impossible.

Proptosis.

(PROTRUSION OF THE EYEBALL.)

CLINICAL LECTURE BY MR. HIGGENS.

March 3rd, 1902.

Causes.—

1. Inflammation within the orbit, with or without the formation of abscess.
2. Hæmorrhage into the orbit.
3. Vascular protrusion of the eyeball.
4. Exophthalmic goitre.
5. Tumours within the orbit:—
   (*a*) Nodes, (*b*) exostoses, (*c*) sarcomata, (*d*) cysts, (*e*) nævi.
6. (*a*) Distension of frontal and possibly of ethmoidal or sphenoidal sinuses; (*b*) tumours commencing in the antrum or other parts of superior maxilla, or the base of the skull, and encroaching on the orbit.
7. Enlargement of eyeball itself from—
   (*a*) Growths, malignant or simple.
   (*b*) Inflammation and suppuration of the whole eyeball (panophthalmitis).
8. Paralysis or stretching of its muscles, allowing the eyeball to drop forwards.

Symptoms.—The most prominent is, of course, the Proptosis; if this is considerable it is seen at once; but if only slight you may have a difficulty in making up your mind as to whether there is protrusion or not. To make sure, place your patient in a low chair, direct him to look forwards and slightly upwards, stand behind him and look down upon the top of his head, then move gently forward, or draw the patient's head back; if either eye is at all in advance of the other, the cornea of that eye will come into view before that of the eye which is in its correct position.

Diplopia, of course, is complained of.

The ophthalmoscope will, in many cases, show retinal congestion, chiefly venous, and in some severe optic neuritis. The ill-effects of the

abnormal condition are seen both in the eyeball itself and in the eyelids. Should the protrusion be so great that the lids cannot be closed over the globe, the cornea will be left unprotected and become opaque and vascular, ulcerated, or it may suppurate and slough. If the protrusion continues for long, the lids become distended and flaccid, their movements much impaired, and the tear puncta may become displaced, giving rise to troublesome watering of the eye.

Treatment.—Before going further, I may just point out that Proptosis, if extreme, must be treated without delay and without reference to its cause. Care must be taken to protect the cornea from injurious exposure by drawing the lids over it, and keeping them fixed by a compress and bandages; if this is not sufficient, the edges of the lids near the outer canthus must be pared, united by sutures and allowed to heal firmly together so as to narrow the palpebral aperture and allow the lids to be closed over the cornea by their own efforts.

Now, we have to consider what is the position of the abscess, tumour, or other cause of the proptosis. In many cases this is obvious, because an abscess may be pointing, fluctuation easily detected, or a tumour felt; in Exophthalmic Goitre the nature of the disease is evident, and in vascular protrusion the pulsation is marked. But there still remains a large number of cases in which we have to judge of the position of the growth, collection of fluid, or other cause, by other means. Notice the direction of the protrusion; if it is straight forward, the cause is probably directly behind the eye; if the globe is pushed at all to one or other side, or up or down, the cause is on the side opposite to that towards which the eye is displaced. Then notice the movement of the eyeball. It is important to make out whether the disease is within the cone formed by the recti muscles or external to it; if it is in the former position, there will be very great impairment of movement from direct interference with the action of the muscles, whereas a very much greater amount of proptosis may occur with little impairment of mobility if the disease is situated outside the muscle cone. The importance of this becomes evident when determining where to make an incision for the evacuation of pus or removal of a growth.

We will now take in detail the causes of Proptosis.

1. *Inflammation within the orbit* may affect the soft tissues, the periosteum or bone, and may end in resolution, the parts returning to their natural condition. Chronic thickening may result, causing more or less permanent protrusion and impaired mobility of the eyeball, or an abscess may form, and in the case of periostitis or ostitis, caries or necrosis of the bony walls may supervene.

Symptoms.—Inflammation within the orbit is accompanied by more or less febrile disturbance, pain of a throbbing character, much increased by pressure, swelling of the lids and conjunctiva, more or less prominence and impaired mobility of the eyeball, intolerance of light and watering of the eye; it may be the result of cold, injuries, or general diseases—as erysipelas or purulent infection, from whatever cause arising, and (in the case of ostitis or periostitis) of syphilis, or may come on in debilitated states of the system after acute diseases (scarlet fever, measles, etc.), or from over lactation. It is not easy to distinguish between inflammation of the periosteum and bone.

2. *Hæmorrhage into the orbit*, sufficient to cause proptosis may occur from spontaneous rupture of a blood vessel, from fracture of its walls, sub-conjunctival ecchymosis, as you are aware, being often a prominent symptom in fracture of the base of the skull, extending through the roof of the orbit, and from foreign bodies, such as the point of a stick, or some sharp instrument entering the orbit. I have seen a case in which the eye was proptosed so as to come in front of the lids from effusion of blood, caused by a piece of glass entering the orbit. The patient had gone to look out of window, and not noticing that it was shut, put his head through the glass. All efforts to return the eyeball failed, and I had to excise it.

Hæmorrhage, sufficient to cause displacement of the eyeball has sometimes occurred from the operation for strabismus.

Symptoms.—You should suspect spontaneous rupture of a vessel as the cause if the proptosis

has come on rather rapidly, without apparent cause, or after some strain. I have seen it occur in children suffering from whooping cough. When the hæmorrhage arises from injury the cause is obvious enough.

3. *Vascular protrusion of the eyeball.—Symptoms.*—The patient complains of noise in the head and feeling of tension, singing in the ears, pain in the orbit and eyeball, all of which are aggravated by stooping or exertion, but are nevertheless most annoying at night. These symptoms are accompanied by more or less protrusion and impaired mobility of the eyeball, dimness of vision, much congestion, principally venous, of the eyelids (especially marked in a large vein extending along the lower eyelid from the inner canthus, which becomes very prominent and pulsates vigorously) and conjunctiva with chemosis. The ophthalmoscope shows venous congestion and rarely pulsation in the retinal arteries. Pulsation can be felt in any part of the orbit and is communicated to the eyeball; it can be controlled by pressure on one or other carotid, generally that on the same side as the proptosis, but in some cases on the opposite side, or only by compression of both, and a bruit may be heard on auscultation over any part of the head, but most distinctly on the brow or other parts immediately adjoining the orbit.

In most cases the symptoms commence at a varying time after an injury to the head, or occur spontaneously and suddenly.

Causes.—Formerly the protrusion was supposed to be caused by aneurism by anastomosis, or, as it is now called, angioma; I am inclined to think that this must be a rare condition. In the majority of cases the cause is a traumatic aneurism of the carotid in the cavernous sinus, or of the ophthalmic artery close to its origin, or an aneurismal varix; in the few cases where a post-mortem has been made, one or other of these conditions was found, and in one which I shall mention presently the cause, with little doubt, was a communication between quite a small artery and vein.

Cases.—In the case of a boy under my care, protrusion of both eyes occurred about ten days after a severe blow on the top of the head from a fall of coal in a mine; both eyes were proptosed to about an equal extent, pulsation could be seen and felt, there was a loud bruit, but no very great amount of discomfort was complained of. Pressure on both carotids was required to stop the pulsation. I diagnosed fracture of the base extending across both carvernous sinuses with rupture of one or both carotids. The patient declined to have any treatment and left the hospital.

Another case was that of a woman æt. 42, a type of the kind of lady one sees about Kent Street and that neighbourhood, without a bonnet, generally half drunk, with a more or less bruised and battered visage, and with a nice musical voice, strongly suggestive of nutmeg-graters. She was careful to impress upon us that she did not drink. No very satisfactory history could be got out of her; but she said that for six months she had been getting deaf in her left ear and had a ticking sound in her head. Two months before she had noticed that the left eye was becoming prominent, and that for a month that the prominence was increased by coughing, stooping, or straining. She owned to an ulcerated throat, but gave no other history of syphilis.

On admission, the left eye is pushed forward as if by a tumour behind it; conjunctiva vascular and œdematous; upper lid puffy and swollen; stooping or coughing causes the eye to protrude more; there are no noises in the head except the ticking already mentioned. The congestion of the conjunctiva is chiefly venous; movements of the eyeball are but little impaired. There is a semi-elastic swelling (dilated vein) in the lower eyelid, which pulsates strongly; pulsation can also be felt in the upper eyelid near the inner canthus, but nowhere else. Both pupils are of the same size, but the left is sluggish in action. There is venous congestion of the retina. There is a loud systolic bruit to be heard all over the head, but most distinctly over the centre of the left parietal bone and the closed eyelids of the left eye, which ceases immediately on compression of the left common carotid. No enlargement of thyroid.

I ligatured the carotid: immediately the ligature was tightened the left side of the face became blanched and all the symptoms disappeared.

Four days after the operation the patient became hemiplegic on the right side, but eventually recovered, and the vascular protrusion was entirely cured.

The following case is, as far as I know, unique; but is, I think, almost certainly an instance of aneurismal varix of a small artery and vein, and shows how vascular protrusion can arise from such a cause.

The patient was a young gentleman who, some months before I saw him, had been struck by a piece of glass from a bursting soda-water bottle, just external to the internal angular process of the frontal bone on the left side; a good-sized wound of the eyelid was caused and sharp hæmorrhage resulted which was stopped by pressure. Much swelling and ecchymosis of the lids followed. The wound healed and the swelling and ecchymosis disappeared, and all appeared to be going well, but shortly before being seen by me the eyeball began to protrude, and much congestion of the eyeballs and conjunctiva was noticed. When I first saw him there was considerable venous congestion of the eyelids and conjunctiva (no chemosis), with marked protrusion of the eyeball in a direction somewhat outwards; there was no diplopia. A small pulsating tumour could be felt near the inner angle of the orbit; a marked thrill was communicated to the eyeball, which could be felt on placing the fingers on the closed lids; a buzzing in the head was complained of, aggravated by stooping, and a small linear cicatrix marked the seat of the original injury. There was much dilatation and tortuosity of the retinal veins, but no pulsation, either arterial or venous, could be detected. There was no impairment of vision.

Pressure on the left carotid at once stopped the pulsation and caused considerable decrease of the venous congestion. I diagnosed aneurismal varix. Perfect rest and pressure applied directly to the part were tried for some months without result. The surgeon under whose care the patient was at length cut down on the pulsating tumour and tied several moderate-sized vessels which appeared to communicate with it. The wound healed without difficulty. I saw the patient a year later. All the symptoms had disappeared; the eye was in its normal position, and the only sign of the former trouble remaining was a small linear cicatrix in the upper eyelid and slight thickening in the position previously occupied by the pulsating tumour.

4. *Exophthalmic goitre* is characterised by protrusion, as a rule, of both eyeballs, but occasionally in the early stages of only one, a peculiar retracted condition of the upper eyelid and impaired mobility of both upper and lower lids, diminished sensibility of the cornea and conjunctiva, accompanied by rapid pulse, disturbance of the heart's action and systolic murmurs in the heart and great blood-vessels of the neck, breathlessness and enlargement of the thyroid. The patients are, with few exceptions, young women, and they are humid and fluttery.

For the purposes of this lecture I have only to consider the proptosis and to point out to you that if it is extreme we must protect the eyes by the means I have already mentioned.

5. *Tumours within the orbit.—Symptoms.*—One symptom is common to all tumours within the orbit, whatever their nature, and it is the one which first attracts the patient's attention, that is, the proptosis: the differential diagnosis is not easy, nor is it of great importance.

A *node* within the orbit should be suspected if the proptosis is accompanied by pain and associated with nodes on the orbital margin or other bones in an obviously syphilitic patient.

Exostosis may be of two kinds, either hard ivory-like masses or soft brittle growths of an open cancellated structure; they should be suspected if the proptosis has been very slowly produced. Certainty in diagnosis can only be arrived at when they have become large enough to be felt by the side of the eyeball.

Sarcoma should be suspected if the patient is past middle life and the proptosis has increased continuously and with moderate rapidity. If the growth has increased sufficiently to be felt it will be found to be firm to a certain extent, yielding but not fluctuating.

Cysts, if they are large enough to be felt, are elastic and fluctuating.

Nævi deep in the orbit would be almost impossible to diagnose, but as a rule they come forward and involve the eyelids or conjunctiva,

to which they give a dusky bluish tinge and soft doughy feel, and their nature is pretty obvious.

If in any case the cause of proptosis is doubtful and it is desirable to make a diagnosis, an exploratory puncture or incision will often clear up any doubt there may be. In making the exploration, take care to make your puncture or incision over the point at which the eyeball is most pushed away from the orbital wall, and to guide the instrument towards the apex of the orbit and not push it through the bone.

The following case is a good instance of a cyst in the orbit, which, had it been diagnosed early, would not have led to loss of vision of one eye. The patient, who was a man of 60, gave a history of proptosis which had commenced four years before I saw him, without apparent cause; he came for advice because the proptosis had increased rather rapidly during the last two or three months. The left eye was protruded forwards and outwards, and its movements much impaired. A firm, non-fluctuating growth could be felt between the outer and lower orbital margin and eyeball; the pupil was active, and the eye could distinguish large objects; the disc was somewhat swollen, and the retina immediately surrounding it hazy; the retinal veins were dilated. The patient was not seen again for six months, when the proptosis, which had been considerably less for some months, had increased; the eye was blind, the retinal veins much engorged. The disc was atrophied. A firm growth could be felt much more distinctly than before in the same position. Two months later, there was a rounded fluctuating projection below the outer canthus; this was punctured with a grooved needle, and a small quantity of purulent fluid escaped. An incision was made, and more purulent fluid, followed by broken down tissue, a large quantity of small transparent cysts, and some blood-stained fluid escaped: after which the eyeball returned to its natural position. The cysts turned out to be hydatids. The case was one of hydatid of the orbit, which was not diagnosed until it began to cure itself by suppuration. Had I made an exploratory puncture the first time I saw the patient, I have little doubt but that his sight would have been saved.

6. (a) *Distension of the frontal sinus* forms a hard tumour often with a fluctuating central portion surrounded by rough bony edges. At the inner angle of the orbit the fluctuating centre is caused by the bone having become absorbed and allowing the fluid contents of the sinus to bulge beneath the skin; the eye is pushed outwards and slightly downwards. There may be double vision, but no impairment of movements.

The tumour has generally followed—but at a long interval—a blow across the upper part of the bridge of the nose, the sequence of events being fracture of bone with closure of the infundibulum and retention of secretion by which the sinus becomes distended. An incision into the tumour gives exit to an enormous amount of stringy yellowish mucus; a probe can be passed through the incision into the sinus of the affected side and across the middle line into that of the opposite side.

Of proptosis from distension of the ethmoidal and sphenoidal sinuses I have no experience.

(b) *Tumours*, most frequently sarcomata, commencing in the antrum or other part of the superior maxilla, may perforate its orbital plate and cause proptosis: their diagnosis presents no difficulty.

If proptosis is caused by a tumour growing from the base of the skull, there is in addition to the displacement of the eyeball distinct evidence of the growth in the pharynx or posterior nares.

7. *Enlargement of the eyeball itself.*

(a) *Proptosis from growths commencing in the eyeball itself* is usually caused by a sarcoma which has commenced within the eyeball, filled its cavity causing enlargement and some prominence. Later on the growth perforates or grows through the sclerotic and invades the tissues of the orbit, much proptosis resulting.

Symptoms.—The eye is blind and probably has been so for some time, its tension is increased, the cornea and iris are in contact; there is no reflex from the fundus; dusky staphylomata exist in the ciliary region or other parts of the sclerotic; if the growth has already invaded the tissues of the orbit the movements of the globe are much restricted or entirely abolished. If the case is of old standing the cornea may be per-

forated and a mass of growth project from the eyeball, which has entirely lost its shape and become merged in the tumour.

(b) *Inflammation* followed by suppuration of the whole eyeball (Panophthalmitis) is generally the result of a wound of the globe followed by septic infection. In the pre-antiseptic days it was by no means an uncommon ending of an operation for cataract, and occasionally followed iridectomy or some more simple operation on the eyeball.

Symptoms.—The lids become red and swollen, the hollow beneath the upper orbital margin quickly filled up; the conjunctiva red and swollen, projects between the partially closed lids, the eyeball becomes enlarged, hard, and pushed forward, together with the red and swollen lids, and the cornea opaque and infiltrated with pus. Pain is severe; the eyeball becomes firmly fixed; if left to itself the cornea sloughs and becomes perforated, giving exit to more or less of the contents of the globe mixed with shreddy pus.

8. *Paralysis of the ocular muscles* occurs in the disease known as Ophthalmoplegia externa. The eye projects straight forward, is moderately proptosed and immovable.

Proptosis from stretching of the ocular muscles follows on long continued protrusion from some one of the other causes I have already mentioned, after the original cause has been removed.

Treatment.—Treat Inflammation within the orbit by rest, a good purge followed by sedatives if there is much pain; hot boracic fomentations frequently used and a hot boracic compress applied over the eye in the intervals. If the patient is strong and full-blooded, apply half-a-dozen or more leeches to the temple.

So soon as pus can be detected, or if its presence is suspected, place the patient under an anæsthetic, make an incision through the skin over the spot where the eye is most pushed away from the orbital margin, and if the abscess is pointing this will at once give exit to the pus. If no pus escapes, push a grooved director into the orbit in various directions, but take care to use no violence. If still no pus escapes leave it alone for the time; but if pus makes its appearance, pass a pair of dressing forceps along the groove in the director, and as soon as they have entered the abscess cavity, open them moderately wide and draw them out still open; by this means you will leave a good opening and run little risk of damaging important structures; then push a gauze drain quite to the bottom of the abscess and apply a hot boracic compress over all. Change the compress as often as may be necessary. If in the course of a few days the discharge has not stopped, examine the orbit carefully with a probe, you will probably come upon bare bone. The case will be one that has begun as periostitis or ostitis, and a sinus will remain which will go on discharging till further notice.

Hæmorrhage into the orbit requires no further treatment than the rest, and slight pressure with a pad and bandage.

Some cases of Vascular Protrusion of the eyeball will recover if treated by complete rest, light pressure with pad and bandage applied over the closed lids, low diet, purgatives, and vascular sedatives, such as tartarated antimony. Others get well spontaneously.

In the case of a lady in North London, about whom I was consulted, what was described as a "crack inside the head" followed by noises, pulsation, bruit, and proptosis, occurred during labour. I advised treatment, but the patient became very ill from other causes, and nothing was done; some months later all symptoms of vascular protrusion had disappeared, and the patient was in her usual health.

Other means failing, you should try digital pressure on whichever carotid stops the pulsation, but you must place your patient under the influence of an anæsthetic, as pressure in the neck cannot otherwise be borne long enough to be of any use. If any of you doubt what I say, try it in your own persons, or let some strong-fingered friend try it for you for three or four minutes. I think at the end of that time you will have had quite enough of it.

All other means failing, there is nothing left but to leave the case alone, or ligature that carotid, pressure on which, it has been found, stops the pulsation. In the case, the notes of which I read to you, the results of ligature were entirely successful. If any of you ever meet

with a case similar to the second one I mentioned (the aneurismal varix) you cannot do better than adopt the same treatment as was employed in it.

Exophthalmic goitre I have already dealt with, so far as it concerns the ophthalmic surgeon.

Tumours of the orbit should be treated in their earlier stages on the supposition that the proptosis may be due to some cause such as a periosteal node which can be absorbed; to this end we should give mercury, or iodide of potassium in as large doses as can be borne. These remedies failing, the tumour must be removed by operation. We must first ascertain whether the tumour is likely to be situated within the cone formed by the recti muscles, or external to it. I have already mentioned the means by which we may arrive at a correct diagnosis. If we decide that the tumour is in the former position, it is probably attached to the eyeball or optic nerve and cannot be removed without removal of the eyeball as well, enucleation of which together with the growth will be required. But if it is in the latter position, its removal may be effected without damage to the globe.

First notice at which part the eyeball is most pushed away from the orbital wall, or if the tumour can be felt, what is its most prominent part; make an incision through the skin in either of these situations, dissect carefully down on to the tumour and then, if possible, separate it from its attachments with the fingers without the use of any instrument; a sarcoma, cyst or nævus can generally be removed by this means alone, aided, perhaps, with a little cutting with blunt-pointed scissors. A spongy exostosis, after it has been well separated from the soft tissues. can be wrenched or twisted out with bone forceps; and do not be surprised if you find that in so doing you have opened the cavity of the nose, or cranium, as these growths often extend as far outside the orbit as into its cavity, and it is somewhat disconcerting to find blood being blown into one's face on each expiration, or to see the dura mater pulsating at the bottom of the wound after removal of the growth. Opening the nasal cavity is of no consequence whatever, and exposure of the dura mater need be followed by no untoward results provided the wound can be kept aseptic. The hard ivory exostosis is very difficult to remove, if it gives rise to but little inconvenience it is best left alone. If its removal appears necessary you can cut it away with gouge, or chisel and mallet, after you have well cleared it of soft parts, but you will be surprised to find how very hard it is and how difficult to cut. If you can procure the instrument, drilling through the base of the tumour in as many places as appear necessary with a dental engine and drill, and then breaking off the partially separated mass with forceps, is much the most rapid and easy.

After removal of any orbital tumour, if the eyeball has been left intact, take care to protect it from damage by uniting the lids over it as I told you when speaking of the treatment of proptosis.

Tumours of the superior maxilla invading the orbit should be treated by removal of the whole or part of that bone, an operation which, although it has been performed more than once or twice in the eye wards, belongs rather to the domain of general surgery, and the same remark applies to tumours commencing about the base of the skull.

A method of removing tumours of the orbit which are not connected with the eyeball, and by which but small risk is run of damaging the globe, has lately been introduced.

The operation is performed as follows:—

Make an incision commencing at the junction of the outer third, with the middle third of the upper margin of the orbit, around its outer angle, and terminating at a point on the lower margin corresponding to that of commencement on the upper; carry the incision down to the bone; next, take up the outer lip of the incision and dissect the skin and orbicularis away, so as to thoroughly expose the outer margin of the orbit and a small portion of the bone in the temporal fossa; then take up the inner lip and separate the parts, including the periosteum, from the margin and outer wall of the orbit, and push the whole, with the orbital contents, inwards; then saw through the thick margin of the orbit at two points, one just below the

external angular process of the frontal bone, and the other just opposite to the upper edge of the zygoma; and then, with a pair of cutting forceps, divide the bone of the outer wall of the orbit, commencing at the saw cuts and inclining the incisions towards each other, so as to remove a good sized V-shaped piece of bone, the point of the V being towards the temporal fossa, and the base at the orbital margin; push the piece of bone backwards, together with any soft parts attached to it, into the temporal fossa; get it held in this position whilst the contents of the orbit are drawn over the opposite side, and you will find that you can thoroughly explore the orbit right back to its apex, and that a tumour growing from its walls can be handled and removed without any very great difficulty, and without injury to the eyeball.

After removal of the tumour, replace the V-shaped piece of bone, re-apply the periosteum to its orbital surface, and close the skin wound with sutures. If necessary, close the lids over the eyeball, paring their edges, and uniting them with sutures.

Distension of the frontal sinus you can cure by drainage. Make an incision through the soft parts over tumour; if the bone is already perforated, thick, yellowish, mucus will at once escape, and you will find that you have entered the sinus. If not, cut away the bone; next wash out the sinus; then pass a little finger up the corresponding nostril; push a director from the opening in the sinus into the superior meatus of the nose until it comes in contact with the finger; then take an eyed probe (to which a drainage tube has been attached by a piece of strong silk), pass it along the groove of the director until it, too, touches the finger; then withdraw the director and push the probe on, guiding it by the finger in the nose until it emerges at the nostril; pull the probe, followed by the silk and drainage tube, through; cut off the silk and probe, leaving the tube; fix it to the forehead by a piece of strapping and leave it.

Wash out the sinus every two or three days during the first fortnight, then leave it alone. Keep the drainage going for three or four months, changing the tube as often as may be necessary; at the end of that time remove it; the skin wound will heal readily, and a permanent opening from the sinus into the nose will be left.

Proptosis from enlargement of the eyeball you should treat by enucleation of the globe. Bear in mind that the majority of cases of protrusion from this cause are due to malignant sarcomata, so be careful to cut the optic nerve right back at the apex of the orbit.

If, as is often the case, the tumour has perforated or grown through the sclerotic, remove all the tissues of the orbit as far as possible, and when the hæmorrhage, which will be pretty free, has been stopped, line the orbit with strips of lint on which has been spread a paste of equal parts of zinc chloride and starch; close the eyelids, if they have not been removed, over the wound, and apply a pad and bandage. In the course of forty-eight hours, or thereabouts, the whole of the soft tissues left will be converted into a slough, to which the lint is adherent, and will separate in due course, leaving the bony walls bare, these will subsequently granulate over and heal.

Panophthalmitis you should treat exactly as you would an abscess in any other part, by free incision (a crucial one through the cornea and surrounding sclerotic is the best). Wash out the globe and dress with hot boracic compresses.

Do not enucleate suppurating eyeballs.

Paralysis of the muscles allowing the eyeball to assume undue prominence is almost invariably due to late syphilis and must be treated accordingly; but in this, and in proptosis due to stretching and laxity, care must be taken by uniting the margins of the lids at the outer canthus to prevent injurious exposure of the cornea.

Papers by Guy's Men.

Carcinoma of the Bladder; Resection of the growth and part of the bladder-wall; Recovery. By Lawrie McGavin, F.R.C.S.—*British Medical Journal*, 22nd March.

On the Treatment of Chorea. By James W. Russell, M.A., M.D., M.R.C.P.—*Treatment* for March.

A Case of Acute Intestinal Obstruction due to Embolism of branches of the Superior Mesenteric Artery. By Dr. W. J. Tyson and Mr. W. W. Linington.—*The Lancet*, 3rd May.

Some Passing Thoughts on Broad Lines of Treatment. By W. J. Tyson, M.D., F.R.C.P.—*Clinical Journal*, 7th May.

Case of Diaphragmatic and Vagus Paralysis after Diphtheria. Death.

A. C., male, æt. 7, was admitted to the diphtheria division of Isolation ward on 15th April, 1902, with general weakness and difficulty in swallowing and in breathing.

History of illness. — Eight weeks before admission patient had a sore throat and was severely ill for some time, suffering considerably from vomiting. There was great swelling about the nose and throat and in the neck. After about a fortnight patient began to recover and regained a little strength, but in rather less than four weeks from the beginning of the sore throat he began to regurgitate food through his nose. His mother also noticed some weakness of the legs and that he squinted. The general weakness progressed, and during the week before admission he was subject to fainting attacks when up, and was kept in bed for four days. For a fortnight he had taken very little food and had wasted.

On admission.—Temperature 98°, pulse 98, respiration 20. Patient was emaciated and appeared very weak and ill.

Nervous system.—Motor symptoms.—The legs were very weak and considerably wasted. There was convergent strabismus, apparently due to weakness of both external recti; some ptosis was observed, but there was no facial paralysis. The voice was almost inaudible; on inspection the soft palate was seen to be relaxed and motionless. The thoracic respiratory movements were exaggerated, but the abdominal movements were reversed, the abdominal wall being retracted during inspiration, this being evidently due to paralysis of the diaphragm.

Sensation appeared to be normal.

Reflexes. — Knee-jerks were absent. Pupils reacted normally.

Circulatory system.—The heart showed signs of hypertrophy and dilatation, and was very irregular.

Respiratory system.—A few râles were audible at the right base, but otherwise the lungs were normal. The respiratory movements are described above under the nervous system.

Throat showed no membrane, but a considerable quantity of muco-pus. A bacteriological examination did not reveal any K.L.B.

Progress and treatment.—Patient was fed by the mouth as an experiment, but it became evident that the nourishment he could take in that way would be quite insufficient, so nasal feeding was resorted to, ʒiv. of milk being given every four hours, together with ʒij. of brandy. He was given a mixture containing ♏j. of Liquor Strychninæ Hydrochloridi every four hours.

16th April. Patient seemed rather weaker; but there was no definite change in his symptoms or physical signs.

17th April. When patient had taken about half his nasal feed at 2 a.m., he suddenly seemed much worse, his pulse becoming very irregular, and his breathing laboured. A hypodermic injection of strychnine was given, and oxygen inhalations ordered. His condition remained precarious for some time, but pulled round somewhat after about an hour and a-half, hypodermic injection of brandy having been given. During the day he seemed feeble, but had a fair pulse, and took the nasal feeds well.

The amount of strychnine in the mixture was doubled, and the dose of brandy in each nasal feed increased to ʒiv.

At 5 p.m. it became evident that there was an increasing amount of secretion in the lungs, and owing to the diaphragmatic paralysis, patient was entirely unable to get rid of this. A hypodermic injection of Liquor Atropinæ Sulphatis ♏½ was given, and repeated some six hours later. A steam kettle was also arranged. At 6 p.m. he had another nasal feed, and his pulse again became irregular. This, however, improved, but his breathing became gradually more laboured, and at 2 a.m. on the 18th, he died, his pulse having been very feeble and irregular for some little time.

Autopsy showed areas of collapse in the lungs and a large heart, the wall of the left ventricle being three-quarters of an inch thick.

Pass List.

University of Cambridge, April, 1902.

Examination for the Degree of Doctor in Medicine.—William Frank Colclough.

University of Durham, April, 1902.

Third Examination for the Degree of Bachelor in Medicine.

O. B. Travers.

Royal College of Physicians of London. April, 1902.

Elected to the Fellowship.—Dr. John Fawcett, M.R.C.P.

Admitted to the Membership on Examination.—Dr. Walter Henry Maxwell Telling.

Royal College of Surgeons Edinburgh, April, 1902.

Examination for the Fellowship.—Albert H. B. Kirkman.

Final Conjoint Examination, April, 1902.

Medicine, Surgery, Midwifery.—*O. W. Richards, *W. E. J. Tuohy.

Medicine and Surgery.—W. J. Davies, *C. J. Pinching.

Medicine and Midwifery.—*A. C. Osburn.

Surgery and Midwifery.—W. H. Cole, J. D. Pearson, C. H. Robertson.

MEDICINE.—*E. G. Allport, *E. Bigg, *M. W. Cohen, R. T. Collins, *H. A. Cutler, *H. Davies-Colley, *T. B. Fawley, *C. E. Gaitskell, *N. N. A. Houghton, *P. D. Hunter, W. W. C. Jones, *A. C. Nash, A. C. Ransford, *H. G. Rashleigh, *D. H. Trail, F. E. Welchman, M. C. Wetherell, *G. T. Wrench.

SURGERY.—A. J. Beadel, J. D. Bridger, G. W. C. Hollist, G. S. Robertson, *F. W. Smith.

MIDWIFERY.—*G. F. Humphreys, F. D. S. Jackson, E. Roberts, F. M. Vincent Smith, W. A. G. Stevens, H. Tipping, A. H. Turner.

* Denotes completion of Examination.

Second Conjoint Examination.

A. D. Crofts, L. G. Davies, G. Hamilton, F. H. Lennox-Jones, J. O. Musson, A. B. O'Brien, J. E. Prentis, W. P. Purdom, C. M. Stevenson, W. Welchman, S. M. Wells, R. O. Williams, H. D. Wyatt.

First Conjoint Examination.

CHEMISTRY.—S. H. Barlow, W. R. Greening, H. J. Hills, G. H. Morris, P. V. G. Pedrick.

ELEMENTARY BIOLOGY.—C. H. R. Bryan, A. Davidson, C. M. Ockwell, H. A. Pallant, St. J. A. M. Tolhurst, H. E. B. Turner.

PRACTICAL PHARMACY.—P. C. V. Bent, L. C. Bowle, W. H. Bush, J. B. Copland, H. B. German, G. F. Hardy, F. D. S. Jackson, H. E. Morris, R. Moyle, M. B. Taylor, *F. C. R. M. Knight.

* Under Four Years Regulations.

Sport.

Association Football.

FIRST XI.—ACCOUNT OF SEASON, 1901–2.

During the season which has recently ended 23 matches have been played, of which 11 were won and 7 lost, the remaining 5 being drawn. It was not till November that the team played well as a whole; previous to this some of the men were unable to "turn out" regularly, and the games were of a somewhat straggling nature. Our line in the Surrey Senior Cup competition was short, and on October 26th we were defeated by West Norwood by 5–1. The chief victories before Christmas were against Cheshunt and Hastings. After this, much improved form was shown at every point of the game with consequent success, and victories were gained over Eastbourne, Ewell and Townley Park, while the Casuals defeated us by the narrow margin of a goal after a fast game. In the Inter-Hospital Cup Ties, having drawn a bye in the first round, we met St. Bart's at Chiswick, the result being a draw of 2–2. In the replayed tie at Winchmore Hill the score was 6–1 in our favour. Against London in the semi-final an exciting game ended in a victory for the hospital by 3–1. Meeting St. Mary's in the final on March 24th, at Clapton, we had the misfortune to lose the services of Denning, centre half, early in the game, and later, those of Pedrick, right half, and ultimately St. Mary's proved victorious by 5–1. On the whole, the season may be regarded as fairly satisfactory. For the hospital there have been scored 59 goals, and against, 45; of the Freshmen who gained their places in the team this season, the halves perhaps take precedence, and all have shown really good form, and worked hard. Denning, at centre half, has been consistently good, while Frankenberg and Pedrick, at left and right half respectively, have materially strengthened the team. At outside right Wragg has proved an acquisition, and with Litchfield at inside right, the pair combine well and make a good wing. The backs and goal-keeper have been sound, and the passing in the forward line was, on the whole, good.

	Club.	Result.
1.	v. Old Harrovians	won 3–0
2.	v. Idlers	won 5–0
3.	v. West Norwood (Surrey Senior Cup)	lost 1–5
4.	v. Royal College of Science	won 3–0
5.	v. Weybridge	drawn 2–2
6.	v. Old Cranleighans	lost 1–2
7.	v. Hastings	won 5–4
8.	v. Beckenham	lost 1–2
9.	v. Old Carthusians	lost 2–9
10.	v. Old Foresters	drawn 0–0
11.	v. Cheshunt	won 1–0
12.	v. Old Eastbournians	won 6–0
13.	v. Townley Park	won 2–0
14.	v. Beckenham	drawn 3–3
15.	v. Eastbourne	won 4–0
16.	v. Weybridge	drawn 1–1
17.	v. Casuals	lost 2–3
18.	v. Ewell	won 3–0
19.	v. St. Bart's (Inter-Hospital Cup, 2nd Round)	drawn 2–2
20.	v. St. Bart's (Replayed Tie)	won 6–1
21.	v. London Hospital (Inter-Hospital Cup, Semi-Final)	won 3–1
22.	v. Tunbridge Wells	lost 2–5
23.	v. St. Mary's Hospital (Inter-Hospital Cup, Final)	lost 1–5

THIRD XI.

	Club.	Result.
1.	v. Kestrel	drawn 1–1
2.	v. Mottingham Reserves	lost 0–5
3.	v. Alleyne "A"	won 6–0
4.	v. Camberwell House	drawn 1–1
5.	v. Norsemen	won 5–3
6.	v. Mackenzie Wanderers	lost 2–4
7.	v. Elstree	won 5–1
8.	v. Hampstead Druids	lost 1–5
9.	v. Winchmore Hill	lost 1–2
10.	v. Quernmore School	won 6–0

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial.

DEAR SIR,—I am enclosing 10s. 6d. for the South African Memorial. It is good for Guy's to have one, and if suitably placed will act as an incentive to inspire loyalty to honour and duty which has been served in the past by antecedent generations of Guy's students.

My own suggestion is but a single and poor thought, but it would be in favour of a proper sculptor's design with ideas of a column to typify strength, with a broken shaft at the top to show the eventuality and the sacrifice of the heroes honoured; below or somewhere in the or rather through the column *a ship's prow and her stern* to symbolise expedition and the sea journeys entailed from our island home; the pedestal could be of rough hewn stone in blocks, and in token of their valour and the durability of the sense of their devotion their names should be let in there in bronze letters, the whole to be in grey marble with the prow and stern of ship in gilt. Any embellishments as wreaths and mottoes to be chosen, the first idea is taken naturally from the Roman "Columna Rostrata," but it is adaptive to this kind of memorial.

Whatever is decided upon it is to be hoped it will not be below the intended result from want of funds.—Yours truly,

3, Ellasdale Road, H. R. BLAKE.
Bognor, Sussex,
5th May, 1902.

DEAR SIR,—I enclose cheque for £1 1s. towards the Memorial Fund for Guy's men who have died at the front. Of the two proposed memorials I should much prefer the one on the grass plot between the two houses, —Yours faithfully,

C. W. EDWARDS.
Alton Lodge,
Woodford Green.
4th May, 1902.

DEAR SIR,—I enclose cheque for a guinea towards the South African Memorial Fund. I quite agree with your remarks in "Passim," that if the funds will only run to an out-door memorial by a "monumental mason" an in-door one of superior workmanship should be chosen. There is sufficient ugly masonry about the Hospital without adding to it,— Yours truly,

R. B. STAMFORD.
Loughborough,
Leicestershire.
4th May, 1902.

South African Memorial Fund.

IT is hoped that those who desire to contribute to this Fund—and we hope there are many others who will give it support—will do so during the next few days, in order that the Committee may know the total amount available for expenditure on the Memorial, and that they may be better guided in coming to a decision as its exact form and character.

The list will be finally closed before the end of the month.

NINTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	161	15	0
Robert Gordon	2	0	0
E. Clifford Beale, F.R.C.P.	1	1	0
John Cheesman, M.D.	1	1	0
C. D. Edwards, M.B.	1	1	0
W. H. Lamb, M.B.	1	1	0
G. L. L. Lawson	1	1	0
W. Henry Loosely	1	1	0
J. T. Musgrave	1	1	0
G. Newton Pitt, M.D.	1	1	0
A. E. Porter, M.D.	1	1	0
R. B. Stamford, F.R.C.S.	1	1	0
J. W. Washbourn, C.M.G., M.D.	1	1	0
H. H. Du Boulay	0	10	6
H. Elliot-Blake	0	10	6
S. F. Holloway	0	10	6
W. G. Nash	0	10	6
F. J. Nicholls, M.B.	0	10	6
Ashby G. Osborn	0	10	6
F. J. M. Palmer, M.B.	0	10	6
Astley C. Roberts	0	10	6
Percy Warner	0	10	6
H. L. Evans, M.B.	0	10	0
C. E. Carpmael, M.B.	0	7	6
W. L. Chubb, M.D.	0	5	0
Hamilton T. Hinton, M.B.	0	5	0
W. H. Peake, M.D.	0	5	0
Staff-Surgeon W. W. Pryn	0	5	0
R. J. Roberts, M.B.	0	5	0
W. Wallis	0	5	0
	£182	8	0

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Passim.

MR. BEERBOHM TREE'S proposed performance at Her Majesty's Theatre in aid of Guy's Hospital Appeal has unadvoidably been postponed for the present. The Countess of Bective's Committee has therefore arranged, by the kind permission of the Duke and Duchess of Westminster, for a grand concert at Grosvenor House on the afternoon of Thursday, the 29th inst., for the same cause. Among a number of distinguished artistes who have promised their servics, are Madame Marie Brema, Madame Sobrino, Mdlle. Sandra Droucker, Miss Lena Ashwell, Mr. Whitney Mockeridge, Dr. Theo. Lierhammer, Mr. Broun, and Herr A. Schmids' Concert Orchestra. Mr. Coleridge Taylor will conduct one of his own compositions.

IN the ordinary round of hospital routine there will be but few who can find time to keep in contact with the literature and topics of the day, a feeling which led to a short and interesting discussion on the proposal to found a Literary Society, but when a periodical contains anything of professional interest, there is usually a great run upon it, and this is true of the last number of the *Nineteenth Century* for its article on the hospital nurse, and of the present number for its reply; and in view of the fact that an ephemeral and frivolous article on the "Pro" was recently published in these columns, a review of it has been included in another column.

TRADITIONALLY from the days when the *Fortnightly Review* and the *Nineteenth Century* reposed gracefully in the School Library, we have connected these two periodicals with learned discussion on the topics of the day, and with a good deal of specialist information which the laity may safely con and remember. But the painful reflection arises, that if the other articles are as misinformed and misleading as the articles on Chloroform a few years back and the Hospital Nurse of yesterday, are we not mistaking assurance for knowledge, and a fluid facile pen for the erudition that comes of intimacy with the subject? When we read an article on Bimetallism or the Zollverein by some unfamiliar name, what guarantee have we, in fact, that the writer is any more qualified to write than the writers (of the gentler sex in both instances) of the methods of anæsthesia with strong preferences for chloroform, and of the case against the hospital nurse?

WE note with interest that the two replies are by well-known and honoured names, both specialists in this particular line, and as well qualified to write as any living writer, but we should feel happier and more trustful if the credentials of the original writer, and her knowledge and experience were as apparent as the undoubted venom of her pen. Can it be that this venerable publication has condescended to the "New Journalism"?

In every ward student's life, the weekly perusal of the fat and comfortable tomes of the *B. M. J.* and the *Lancet* probably occurs, and one is apt to come away from the perusal of them with the feeling that they are good but not satisfactory. There are rarities in abundance, multiple clinical effusions written to order, abstruse pathological theories, but few really helpful articles to the student or practitioner: there is more interest practically and personally in the correspondence, the answers to doubts and queries, and the occasional recommendation of a fair practitioner.

THAT this is so is demonstrated by the fact that the *Lancet's* name was made by defiance of authority and tradition, by publishing the latest hospital novelty, and by stern unbending criticism of public blunders. Would that that position had been maintained through the South African medical fiascos, but alas! in defiance of tradition, the *Lancet* was found on the side of optimism and official denial. It is also plain, from the repeated attempts to bring out a medical journal which shall appeal to the general practitioner, and it may be said that in the minor medical publications, there are occasionally sound practical papers, *e.g.*, such as the one headed "Empyema" in the *Clinical Journal.*

There are notoriously few things of more importance to practitioners than the management and dietary of acute conditions, such as a railway smash, a ruptured extra-uterine or suppurative peritonitis, not to mention prolonged abdominal sections and the diet of infants, and it may be said that the recently qualified man rarely, if ever, knows much about the points involved, and we shall have much pleasure in attempting to provoke a discussion on the ideal method by publishing in our next issue what is actually done in the various wards the names of which we need not mention, but which will be obvious to all who wish to know it, though the author claims no originality or finality for the methods.

The correspondence and the subscriptions to the South African Memorial still continue to arrive and we welcome both. It is to be hoped something will soon be decided. We must confess that a small artistic and architectural gem would be a relief to the eye from the colossal, monstrous and massive buildings around; and we can only hope that when the decision is taken it will be our good fortune to find a good design (symbolical if possible, one correspondent suggests), but not heavy or gross as so many modern monuments are.

Many will have read a notice casually posted up by a firm of chemists in the gateway of the College without considering what a remarkable document it really is. It consists of a list of vacancies for medical officers on large ships of varied destinations, pay and periods of service, concluding with the statement that the firm charges a fee of one to three guineas. It amounts to this, that in a contract for drugs the medical man is included, and we cannot but think that this position is as undignified for a member of a learned profession as it is significant of the tendency to exploit medicine for commercial purposes. It is to be hoped some effort will be made to secure that shipping companies will apply to the properly accredited medical agencies for medical men, rather than expect to be well served from such sources.

We are asked to remind old Guy's men that the Past and Present Cricket Match will take place at Honor Oak Park on Saturday, June 21st, at 11 a.m. After their extremely satisfactory win of last year, it is to be hoped that the Past captain, Mr. F. J. Nicholls, will be able to lead a good side into the field. Mr. C. H. Fagge, 22, St. Thomas's Street, S.E., will be glad to hear from anyone wishing to play.

Last Thursday the first of the series of the Gordon Lectures on Experimental Pathology was given. We must congratulate Dr. Walker on the lucidity with which he expresses himself, and we hope before long to hear something of his own original research. He rightly touched on the generosity of Mr. Gordon in founding the Scholarship, which cannot but be productive of good to humanity. The lectures are given every Thursday at 4 p.m. in the Physiological Theatre.

Guy's Dental Travelling Scholarship.

We would like to call the attention of Licentiates of Dental Surgery of the Royal College of Surgeons of England, who have been educated at Guy's, to the fact that applications for the above-named scholarship for the present year must be sent to the Treasurer, on or before June 1st next.

The value of the scholarship is £100, and it is awarded every other year, on the condition that the scholar shall devote six months, at least, to practical work at a foreign dental school.

It was felt by the Staff that a thorough post-graduate course at one of the best Colonial, Continental or American Schools would give the Scholar a good opportunity of acquiring an increased knowlege and skill in the specialty of Dentistry.

It may, too, prove to the recipient a valuable stepping-stone in Guy's Dental School, as he may subsequently be required by the Dental Council to act as a Staff or Extra Demonstrator.

We congratulate the authorities in striving to keep the teaching in the department up to modern ideals.

Traumatic Fever.

THE TREASURER'S PRIZE ESSAY.

BY P. N. BLAKE ODGERS, B.A.

MR. PRESIDENT AND GENTLEMEN,—In essaying to give some account of Traumatic Fever it were well, I think, to divide my paper into five parts:—

I. I would first attempt to give a definition and description of this fever or group of fevers.

II. In the second place, I should like to discuss the somewhat vexed question of its pathology.

III. Then let me consider its incidence, under what conditions and with what frequency it occurs.

IV. I shall then describe some of its complications and its relation to the onset of other diseases:

V. and lastly, dwell for a minute on the significance of this fever, and on the measures to be adopted to prevent its occurrence.

I. In the pre-antiseptic days it was thought essential that, after the shock of the operation, a brisk inflammatory reaction should ensue. After an amputation, for example, the water dressings would be removed on the second day, and a considerable sero-sanguineous discharge would be found. On the third day this discharge would be mixed with pus. By the end of the week after the operation, free suppuration with the separation of the ligatures, and the sloughs caused by them, would have occurred, and if the wound were healing well, healthy granulation tissue would have sprung up. The temperature during this time was not unnaturally raised, and fell at the end of five, six, or seven days, with the onset of a free discharge and the appearance of the granulations. To this "reaction" the term "simple traumatic fever" was applied. (See Chart VI.) With the advent of antisepsis, it was imagined that a rise of temperature following operations would be a thing of the past; these expectations have not, however, been absolutely fulfilled, and the following varieties of surgical fever were first distinguished in 1875 by Volkmann and Genzmer:—

(*a*) "Simple," "aseptic," traumatic fever, or, as others have styled it, "ferment," "resorption," "after-fever," or "benign" traumatic fever.

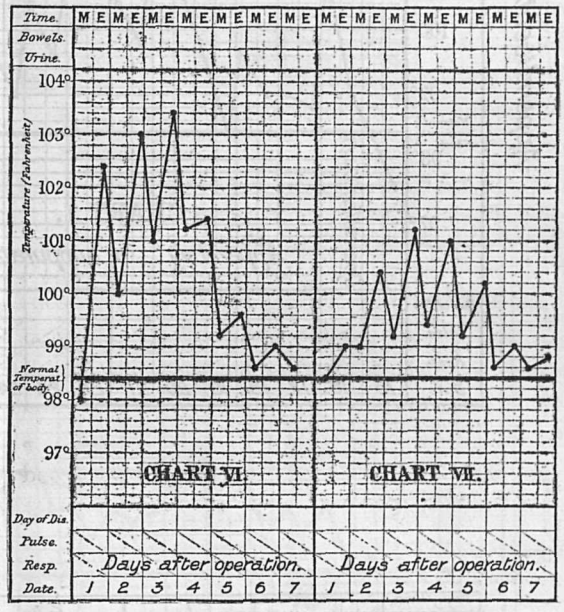
(*b*) "Septic," "secondary," or "malignant" traumatic fever.

The latter is associated with the absorption of the toxines of micro-organisms—a condition of sapræmia—or with the actual entrance of pyococci into the circulation—a condition of septicæmia. Of this variety of fever I do not intend to make mention again, except to contrast with it the simple aseptic type. It is to the fever which occurs after apparently absolutely aseptic operations or in simple fractures, that the term traumatic fever is usually applied in these days, and accepting this narrower definition, it is to this form that I am going to confine myself in this paper.

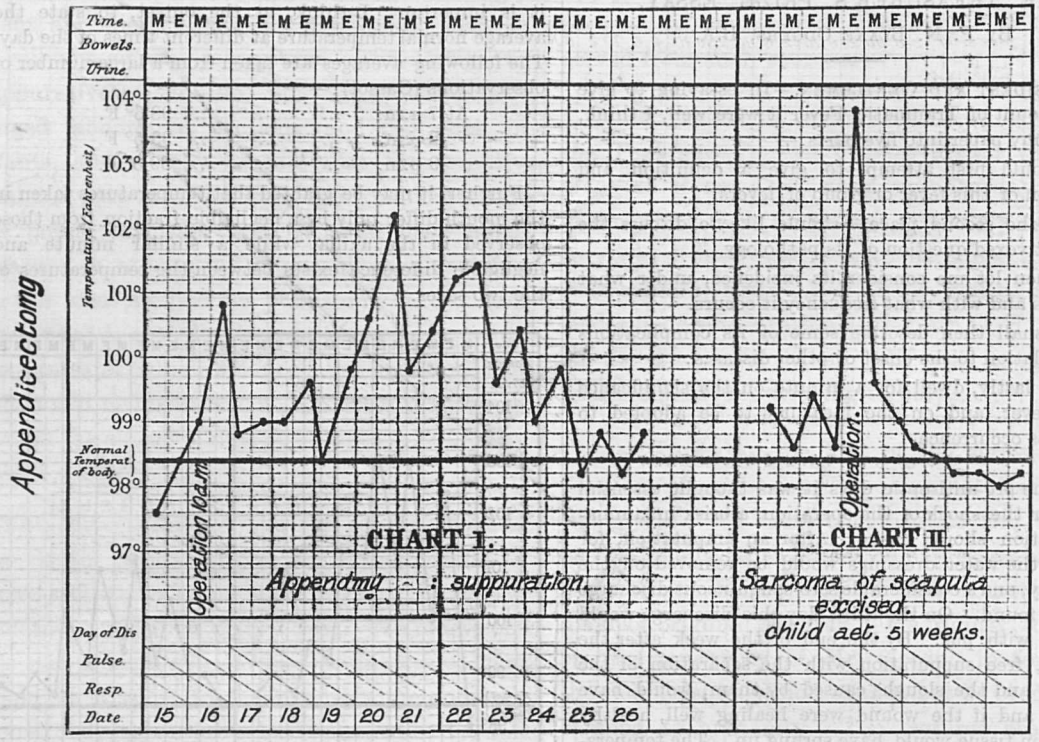
Before describing a fever in which the temperature is oftentimes but slightly raised, in order to combat the objection that such a rise is within physiological limits, it is important, I think, at the outset, to state the average normal temperature at different times of the day. The following averages are taken from a large number of observations (Gassot):—

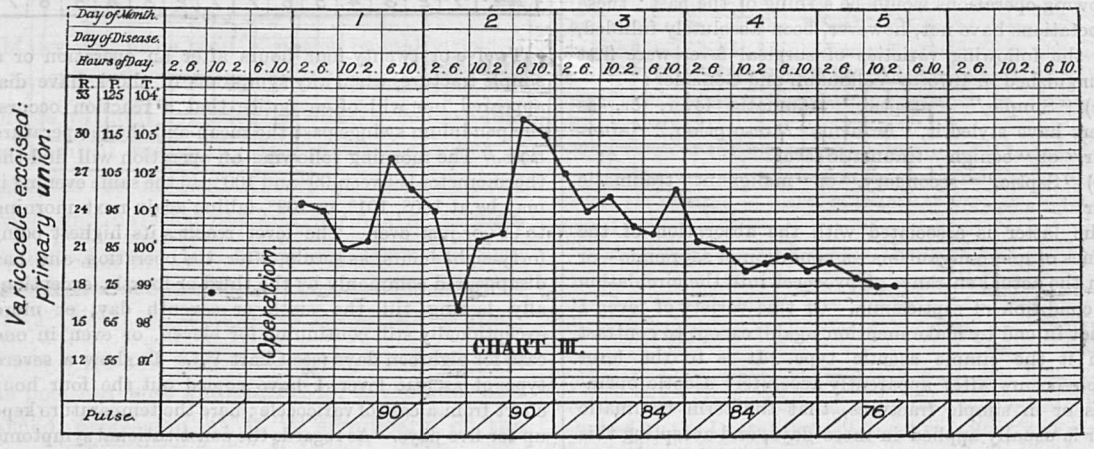
At 7 a.m.	...	...	...	98·6° F.
2 p.m.	...	...	...	99·5° F.
9 p.m.	...	...	...	99·3° F.

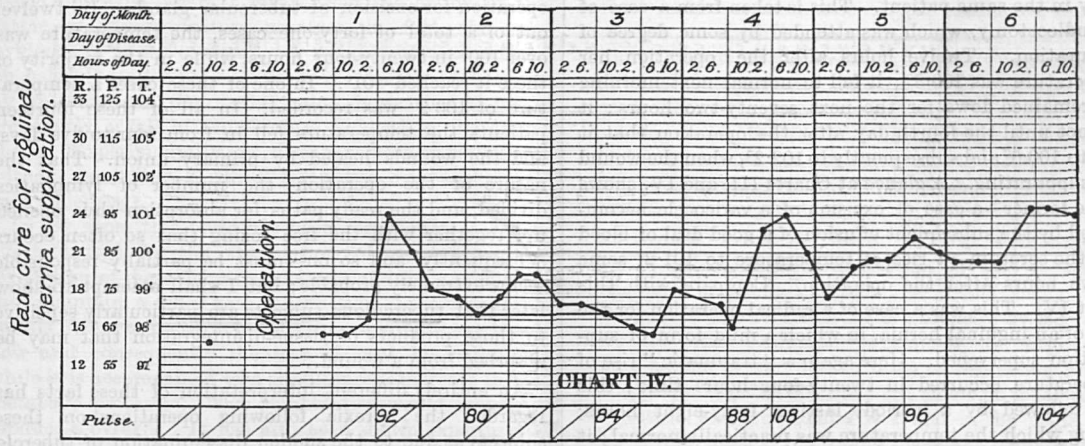
Further, it may be granted that temperatures taken in the mouth differ only by a negligible fraction from those observed in the axilla, while a similar minute and negligible difference exists between the temperatures of the two sexes.

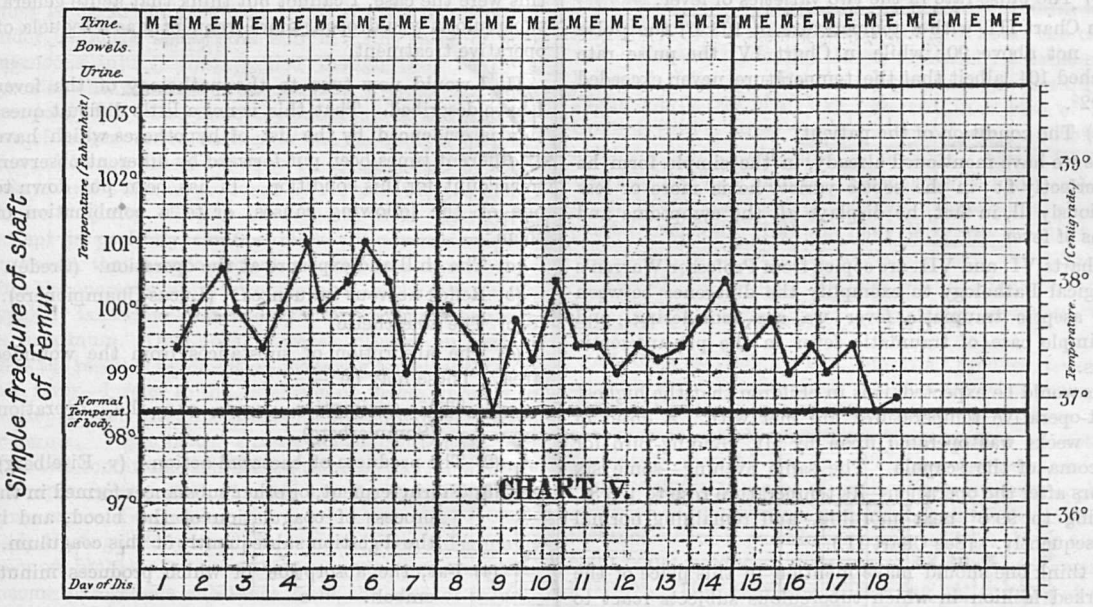


Twelve or twenty-four hours after an operation or a simple fracture, when any symptoms of shock have disappeared, one will often notice that a reaction occurs, the pendulum swings past the mean and the temperature rises. The morning following an operation will find the thermometer between 99° and 100°; in the same evening it may be at 100°, 101°, or 102°, falling again next morning to 99° or just over. The fever reaches its highest point forty-eight hours, as a rule, after the operation, and has disappeared commonly by the third or fourth, exceptionally lasting till the sixth or seventh day, or more exceptionally still continuing for eleven, or even in one case for eighteen days (see Chart V.). To show a severe type of aseptic fever, I have copied out the four hour chart from a case of varicocele; here the temperature kept up for five days. As regards the constitutional symptoms of fever presented by the patient during this time, they are generally conspicuous by their absence. If it were


Appendicectomy
Time.
Bowels.
Urine.
Temperature (Fahrenheit)
104°
103°
102°
101°
100°
99°
Normal Temperat. of body
98°
97°
Operation 10a.m.
CHART I.
Appendicitis : suppuration.
Operation.
CHART II.
Sarcoma of scapula excised.
child aet. 5 weeks.
40°
39°
38°
37°
36°
35°
Temperature (Centigrade)
Day of Dis
Pulse.
Resp.
Date
15 16 17 18 19 20 21 22 23 24 25 26


Varicocele excised: primary union.
Day of Month.
Day of Disease.
Hours of Day.
1 2 3 4 5
2.6. 10.2. 6.10.
R. P. T.
33 125 104°
30 115 105°
27 105 102°
24 95 101°
21 85 100°
18 75 99°
15 65 98°
12 55 97°
Operation.
CHART III.
Pulse.
90 90 84 84 76





not for the thermometer, the rise of temperature would probably not be suspected. He has no headache, his mind is clear, his appetite good His face is not flushed, while his tongue is clean, and the pulse rate is not raised in proportion to the temperature. This last fact is well brought out by a reference to Chart III.: forty-eight hours after the operation the temperature is 103·4°, while the pulse rate remains at 90°.

About the wound in such cases there is no sign of local inflammation; it heals by primary union and is apparently entirely aseptic.

Accompanying the fever, a blood examination will often show a leucocytosis. For instance, in three cases, two of osteotomy and one of osteoclasm, the first showed an increase from 13,000 to 26,000 in the white corpuscles forty-eight hours after operation; in a second, an increase from 9,000 to 11,375; in a third, the leucocytes were increased five-fold (Schnitzler and Ewald).

The difference between this simple "aseptic" fever and the "septic" variety is well demonstrated by a comparison of Charts I., III., and IV. The chief features which distinguish them are :—

(*a*) The earlier appearance of the simple form. A reference to Chart I. shows both forms occurring successively in the same patient. This is taken from a case of appendicectomy, which was attended by some degree of suppuration. Twelve hours after the operation her temperature was 100·8°; it fell to normal next morning and remained down for the next seventy-two hours; it was not until the fourth day after the operation that it rose to 100·6° and subsequently to 102·2°, when the wound was suppurating. A glance at Charts III. and IV. shows in the former—a case of excision of a varicocele accompanied by the subsequent effusion of a good deal of blood into the scrotum—a rise of temperature to 101·2° some twelve hours after the operation. Compare with this Chart IV. This was a case of a radical operation for the cure of an inguinal hernia, in which a mild form of suppuration supervened. Here again a "traumatic" rise of temperature occurred in twenty-four hours' time; this was followed by a period, lasting forty-eight hours, during which the temperature was practically normal; it was not until the fourth day that the septic fever due to absorption from the suppurating wound declared itself.

(*b*) The pulse rate in the two varieties of fever.

In Chart III. with a temperature of 103·4°, the pulse was not above 90; while in Chart IV. the pulse rate reached 104, albeit that the temperature never exceeded 101·2°.

(*c*) The condition of the patient.

As we have mentioned already, in the simple form he is perfectly fit; in the septic variety he is more or less obviously ill, in fact, he displays all the symptoms and signs of fever.

Charts VI. and VII. are copied from Professor Warren's Surgical Pathology to exemplify the difference between the aseptic traumatic fever we are considering, and a simple case of traumatic fever in the pre-antiseptic days.

As would be expected, it is in children that the highest post-operative temperatures are met with. A child of five weeks was operated upon by Mr. Golding-Bird for sarcoma of the scapula. The same evening—some six hours after the operation—its temperature rose to 103·8°, falling to 99·6° next morning, and remaining normal subsequently. (See Chart II.).

I think one should make mention in this place of the marked fashion in which tuberculous subjects react to operations. Mr. Camps told me the other day of the case of a little girl to whom gas was administered—she had taken all her former anæsthetics extremely badly—to allow of an old sinus about her hip-joint being scraped and dressed. The same evening her temperature was over 104°; next morning it was normal, and remained so subsequently. In the Hospital Reports of 1878, Mr. Henry Davey mentions a similar case. Chloroform was administered to a tuberculous patient, in order that his hip-joint might be examined. After this manipulation, the temperature twelve hours later was 102·4°, and remained above 100° for some days.

Referring to the surgical reports, I found the best marked cases of traumatic fever occurring after the operation for excision of tubercular glands. In twelve, out of a total of forty-one cases, the temperature was over 100° in twenty-four hours, while in the majority of these it reached 101°. In one of these cases a temperature of 103 2° was recorded. In all of these fourteen patients the temperature fell in from four to five days, and the wounds healed by primary union. That the nature of the operation—the number of lymphatics divided, and the ready paths for absorption thus opened up, together with the free oozing that so often occurs subsequently, and so on—must be partially responsible seems extremely probable; but I shall attempt to show later that tuberculous subjects are particularly sensitive to those products of tissue-disintegration that may be absorbed from a wound.

An entirely different interpretation of these facts has regarded the pyrexia following operations on these subjects as due to the sudden dissemination of tubercle bacilli in the circulation, while the previous development of antitoxin only prevents a widespread infection. If this were the case, I cannot but think that acute general tuberculosis would occur more frequently as a sequela of operative treatment.

II. I would now turn to the pathology of the fever I have described. That this is not a little difficult question is evidenced by the list of hypotheses which have at different times been put forward by different observers to account for this condition. It has been put down to one of the following causes, or to a combination of them:—

(*a*) The chill and exposure at the operation. (Credé).

(*b*) Reflex nervous influences. (Lucas-Championère).

(*c*) The anæsthetic.

(*d*) The absorption of substances from the wounded area. These may be:—

(1) The antiseptics used at the operation. (Sommerberg).

(2) The products of bacterial action. (v. Eiselberg).

(3) Fibrin ferment, or other substances formed in the process of coagulation of the blood, and in the digestion subsequently of this coagulum.

(4) Fat, the absorption of which produces minute emboli.

(*a*) Taking these in order, one can dismiss the first immediately. The fever has not been noticed to bear any relation either to the length of the operation or to the amount of the exposure, to which the patient is subjected. For example, to take two cases at random, a gastro-jejunostomy has a temperature of 100° twenty-four hours after the operation, while that of a patient, whose tendo Achilles is divided, is 100·6° after the same interval of time. The precautions, too, which are adopted in the direction of warm clothing for the patient and in raising the temperature of the theatre must reduce the effects of chill to a nullity.

(*b*) In the matter of the anæsthetic, there is no evidence, experimental or otherwise, that chloroform or ether can cause a pyrexia—apart, I mean, from the action of the latter on the respiratory passages—in fact, the only evidence is to the contrary. A number of observations on patients under chloroform have recently been made by an American (Da Costa), who shows that there is constantly a fall of temperature induced by the anæsthetic. Experimentally, too, dogs have been anæsthetised without producing a rise of temperature in any single case (Edelberg).

(*c*) By some this fever has been regarded as a reflex effect caused by the stimulation of sensory nerves. Excitation of these nerves at the seat of injury produces, they maintain, a reflex vaso-constriction of the cutaneous vessels; this, in its turn, lessens the rapidity of the blood flow and consequently the loss of heat by radiation, while it is accompanied by a simultaneous increase in the metabolic processes. This combination would obviously produce a pyrexia. It has also been shown experimentally that, although a strong stimulus applied to a sensory nerve lowers the body temperature, if the stimulus be less intense, a rise of temperature is seen. Against this must be urged the fact that in many cases of operation under complete anæsthesia and in many cases of subcutaneous injury, accompanied though they be by a pyrexia, the shock to the nervous system must be practically nil. The most obvious result of the stimulation of sensory nerve endings is the production of pain. Now, although this fever may be accompained by some pain from the tension produced by the extravasated blood, in the majority of cases the reports state that "the patient is perfectly comfortable." We would expect, moreover, that a reflex effect would occur immediately after the operation or injury; this fever, on the other hand, typically takes four and twenty hours or longer to reach its maximum. One does, however, observe in certain cases the result of reflex action occurring coincidently with this fever—I refer to the retention of urine, which is so frequently seen after operations for the cure of varicocele or hernia. What in these cases the connection between these two conditions is, if indeed there be any, or whether a temporary retention of urine can in itself raise the temperature, I do not know.

(*d*) Having briefly considered possibilities, we come to the more probable source of this fever, viz., the absorption of some pyrogenous substance from the area of injury.

(1) That antiseptics may be absorbed from a wound was a fact early recognised. It is not surprising, then, that in the early days of antiseptics, traumatic fever was put down to the absorption of carbolic acid.

Edelberg investigated the subject from this point of view and gave carbolic acid to cats and dogs by the mouth in increasing doses until they received gr. xl. in the dose; he also gave subcutaneous and intravenous injections and finally rubbed it into the skin. He found in all these cases that after an inconstant pyrexia it causes a depression of temperature. In cases of carbolic acid poisoning in man it is rare, too, to find any elevation of temperature. As regards the clinical evidence against this hypothesis, Mr. Davy, writing at a time when carbolic acid was the antiseptic par excellence, remarks in a paper, to which I have already referred, that in the six months that he was dressing he hardly saw a case in which the temperature, subsequent to the operation, exceeded 99°. He quotes cases of excision of the breast, of strangulated hernia, and of trephining. Add to this the fact that the condition of the urine provides immediate evidence of any considerable absorption of this acid.

As regards iodoform, there are well authenticated cases of poisoning from absorption of this substance, particularly in young children and in old people. But here again, if the temperature is produced by iodoform, there are other symptoms to indicate its absorption. Such a patient is said first to become melancholy and to lose appetite; he has the constant smell of iodoform in his nostrils, and free iodine is found in the urine. In more severe cases of poisoning there are hallucinations and delirium going on to stupor and collapse (Nussbaum).

Mr. Watson Cheyne records a case which proved fatal. Two drachms of a 10 per cent. solution of iodoform were injected into an iliac abscess; in a few hours the child was collapsed, it vomited blood and finally became restless and delirious, with a temperature of 104·6°. A slight febrile reaction was observed in a case of Mr. Golding-Bird's, after the injection of an emulsion of iodoform into a tubercular ankle-joint. I have found a case recorded by Professor Warren in which hyd. perchlor. (1 in 1,000) was used to syringe a knee-joint after a partial excision. Half an hour later the whole body was covered with a typical scarlatinal rash, which lasted for twenty-four hours. Mercury was found in the urine and in the fæces, but no rise of temperature was observed.

All these antiseptics can, however, produce fever in another way than by their actual absorption, namely, through the local irritation they are apt to produce. In the skin to which they have been applied an actual dermatitis may be set up. This one has seen oneself occasionally in the case of antiseptic compresses applied preparatory to operation, and Mr. Lockwood describes an instance where a perchloride compress kept on for forty-eight hours produced blistering and a number of regular pustules. They may also irritate the cut surfaces of the wound and so cause a considerable exudation of blood and serum. This latter will not only favour the growth of pyococci and thus predispose to suppuration, but also, if it remains sterile, may set up an aseptic fever in the manner presently to be considered.

(2) Is there such a thing as "aseptic" traumatic fever? Is it not rather a mild form of sapræmia or septicæmia due to the absorption of the products of micro-organisms or of the pyococci themselves? That this was the case was upheld by v. Eiselberg, who published four cases of aseptic fever, in three of which he found cocci in the blood. In the first a parotid

tumour was removed; forty-eight hours after the operation the temperature was 102° F., and the staphylococcus pyogenes albus was cultivated from the blood. In three days the fever had disappeared and the blood was sterile. In a second case, a Syme's amputation was performed. On the same day the evening temperature recorded was 102° F., and a streptococcus was found in the blood. In a third case—an excision of the elbow-joint—in forty-eight hours the temperature was 103·5° F., and the staphylococcus pyogenes aureus was similarly cultivated. How far these observations are trustworthy I do not pretend to know; certainly in cases of infective endocarditis, cultivations of the blood have given the most divergent results.

Further, it has been proved that to obtain "primary union," the wound need not be absolutely sterile. In many cases staphylococci have been found in number in apparently perfectly aseptic wounds during the first few days after an operation. (Wölfler). If this be true, one must suppose that the micro-organisms are of slight virulence—such an attenuation has been produced by growing the anthrax bacillus in the presence of a dilute solution of carbolic acid—while the absorption of themselves, or of their toxines, is soon prevented by the inflammatory reaction of the healing wound.

This theory would work well for the fever occurring after surgical operations, but in the case of fractures or other subcutaneous injuries, it must be amplified. The upholders of it would say that the bruised skin provides an easy atrium for the micro-organisms, constantly present therein, to infect the damaged tissues, or they would have recourse to the so called doctrine of "auto-infection." Of the latter, one should perhaps speak in some detail, because if it be true, it affords at once a ready explanation, not only of this aseptic fever, but also of those cases where suppuration occurs, even after all the canons of antisepsis and asepsis have been complied with in the strictest possible fashion.

Two patients have the same operation performed upon them; both are in apparently excellent health, and both wounds heal by primary union; one has a considerable fever during the first few days, the other has none. Two patients are operated upon with the same antiseptic and aseptic precautions, by the same surgeon, with the same dressers; one suppurates and the other does not. In such cases one feels that the personal element, the condition of the patient prior to the operation must have something to do with these differences. In health, the blood of man is said to be sterile (Meissner); although in rabbits, in perfect health, cocci have been found in the blood, in the heart, the spleen, the testicle. Again, if the general vitality be depressed by such poisons as phosphorus, Mr. Watson Cheyne has shown that the tissues contain a number of micro-organisms. Similarly, a local injury will lower the power of resistance in the damaged tissues, which will now arrest any bacteria that are in the circulation. After an injection of putrid fluid into a young ram, one testicle was crushed; a few days later it was gangrenous (Chaveau). Compare with these experiments such cases as the following, which are given by Mr. Lockwood, in his "Aseptic Surgery":—

A boy had a simple fracture of the ulna. He was a schoolboy, in apparently perfect health, and yet suppuration occurred.

In another case the source of infection was more obvious. The median nerve, involved in an old scar, was cut down upon. The boy seemed perfectly well before, and for some days after, the operation. His wound was painless, and apparently healed. He then developed a diphtheritic sore throat, and his wound suppurated.

A number of cases of osteomyelitis, occurring after simple fractures, have been found to be due to infection from some slight peripheral focus of suppuration. In this connection, as showing the presence of micro-organisms in the blood in cases where they would scarcely be suspected, one might refer to the recent paper of Dr. Bryant's, in the last volume of the Reports, wherein he demonstrates the presence of a bacillus in a number of cases of apparently aseptic thrombi.

One must, then, I think, admit the possibility that in some of these cases the term "aseptic" fever is a misnomer, and that bacterial toxines are at the root of the matter. Against this, however, is the comparison I have already made between the septic and aseptic forms of pyrexia. In both the temperature may be equally high, but here their similarity ends. The constitutional and topical effects are absolutely different.

(3) I come next to the consideration of the suggestion that it is the absorption of the effused blood in a surgical wound or injury that is responsible for the rise of temperature. I would first give the proofs of this statement and then attempt to go into the evidence as to what particular substance or substances may cause the pyrexia.

As regards the clinical evidence for this assertion, it is those operations, where considerable subsequent oozing occurs, after which fever may be most frequently looked for. I have already referred to Chart II.: it is taken from a case of varicocele, where there was a considerable effusion of blood into one side of the scrotum after the operation, owing to the slipping of a ligature. In another case—of radical cure for inguinal hernia—that I have a note of, there was a temperature of 101° in forty-eight hours, and it reached 100° for five days subsequently. The report here also states that a similar condition of the scrotum existed as that noticed in the previous case. Professor Warren records two cases of excision of the breast and axillary glands for carcinoma. In one of them (see Chart VII.) the dressings had to be removed the same evening after the operation owing to the persistent oozing; here the temperature kept up for eleven days. In a precisely similar operation, done about the same time, there was no oozing; bone drainage tubes were used, and the wound was not redressed till the tenth day. In this case, after a rise to 99·5° a few hours after the operation, the temperature remained normal throughout. A rather striking case of fever, which was apparently due to absorption of blood clot, is that of a young woman,

who had continued high fever for some weeks, caused by a blood cyst in her thigh, which had developed from a cavernous angioma. The fever disappeared with the excision of the cyst (Langenbeck and Cramer).

Is not the mild degree of fever not infrequently seen in puerperal women for two or three days after confinement another instance of this "absorption fever," and cannot a similar explanation be used to account for the continuous slight pyrexia accompanying the rapid growth of a sarcoma with its blood cysts? I remember a case of sarcoma of the cervical glands in a young girl that had all the appearances of an acute abscess, and was sent up by a doctor with this diagnosis. Her temperature was constantly between 100° and 101°.

In indirect support of the view that absorption of effused blood may give rise to a pyrexia are two cases of simple fractures, in which the application of a plaster splint was followed by a rise of temperature. If one is to believe that a mechanical factor can play a part in absorption from the tissues, the pressure of the splint would naturally increase the tension of the fluid, and so further its resorption. In the more striking of these, a patient after fracturing his tibia had a normal temperature for three days; a Bavarian splint was then put on and in twelve hours the temperature was 101·6°. In the same direction points the fact that oftentimes a compound fracture treated aseptically gives rise to less pyrexia than a similar simple one. It has also been observed that in many cases after simple fractures, albumen appears in the urine for the first three or four days; brown masses are also seen, which are regarded as the product of the destruction of red blood corpuscles (Riedel). Similar coagulable proteid has been found in the urine in many cases of myeloid sarcoma. In a few cases of fracture jaundice has been noticed, while bile pigments have been found in the urine at the same time. The jaundice has been said to be hæmatogenous and due to the absorption of blood pigment from the area of injury.

Experimentally, Billroth showed that the fresh aseptic discharge from a recent wound, when injected into an animal subcutaneously would cause a pyrexia, and a like result was obtained with the serum expressed from a blood-clot (Köhler). Similar fever has been caused by the transfusion of another animal's blood or serum, or after injections of water or of a solution of hæmoglobin, while extracts of fresh tissues, of muscle, of liver and of thyroid, are all actively pyrogenic (Rouqués).

If we grant, then, that the absorption of blood-clot has something to do with the production of this pyrexia, what particular substance is responsible for it?

Edelberg first studied this question and came to the conclusion that in fibrin ferment he had found an actively pyrogenic substance, which occurs in, and may be absorbed in extravasated blood. In two cases after amputation, he satisfied himself of the presence of free fibrin ferment in the blood of the patient, while the injection of this ferment into animals produced a febrile reaction. These results were confirmed; of nineteen patients with aseptic traumatic fever, twelve had the free ferment in their blood (Hammerschlag), while other ferments, pepsin and trypsin have been shown to have the same fever-producing properties.

The most recent paper on this subject that I can find, was published in 1896 by Schnitzler and Ewald. They revised the observations previously made in two well-marked cases of traumatic fever; one was an old dislocation of the hip-joint in which several unsuccessful attempts at reduction had produced a pyrexia (T. 100·4°), while in the other there was a traumatic aneurysm of the popliteal artery (T. 102·2°). In both of these, blood was withdrawn immediately into ten times its quantity of alcohol, but no ferment was found. Fibrin ferment, too, does not appear, if pure, to be capable of producing fever (Köhler).

They maintain that one of two substances is responsible for the traumatic rise of temperature, both of which occur in extravasations of blood—nucleo-proteid and albumose. That both these substances have a somewhat similar toxic action, when injected into an animal, is shown by the effect that both, under certain circumstances, produce on the coagulability of the blood. With regard to the former of these substances, their proof is not very convincing. On the supposition that the amount of uric acid excreted bears a relation to the quantity of nucleo-proteid absorbed (Horbaczewski — Weintrand), they proceed to show that twelve to eighteen hours after fractures, osteotomies or osteoclasms, the uric acid in the patient's urine was increased threefold. Again, on the rabbit they divided the popliteal artery subcutaneously and found subsequently an increase in the alloxur nitrogen to twice its normal quantity. This increase in uric acid is, they say, to be accounted for by the absorption of nucleo-proteid from the extravasated blood, but they themselves also found that a considerable leucocytosis occurs coincidently. In one case of osteoclasm, the count was 32,250 per cubic millimetre, and I imagine that such an increase in the white corpuscles would of itself be responsible for the increase in the uric acid: such a relation certainly holds in cases of leukæmia.

In the albumoses we have substances which are all actively pyrogenic. Thus, deutero-albumose, prepared from a peptic digestion, will give rise to a pyrexia, if it be injected into a healthy animal. They are, further, constantly produced in subcutaneous blood extravasations, as the result of the digestion of the coagulum by the proteolytic ferment of the tissues. The power that horse serum has of producing a temporary rise of temperature almost immediately after its injection into animals, or into man, has been found by Dr. Salter to be due to a substance which apparently belongs to this same class; it is, at any rate, a soluble proteid, precipitated by ammonium sulphate. Moreover, albumoses have been shown to be present in the urine in cases of aseptic fever in man, *e.g.*, after a hydrocele had been injected with tinct. iodi. In animals albumosuria has been experimentally produced by a subcutaneous injection of silver nitrate. (Krehl and Matthes).

If these observations be correct, aseptic fever would seem to be brought into line with that produced by the absorption of bacterial toxines, in many of which (*e.g.*, those of anthrax, tetanus, and diphtheria), the pyrogenic principle has been shown by Professor Sidney Martin to belong to this same group of the albumoses. Albumose, too, is contained in Koch's tuberculia, and here again it is apparently responsible for the rise of temperature observed after injections of that substance. In this connection, it is interesting to note that tuberculous animals react to albumose injections in a very much more marked fashion than do those in health (Matthes), while it is just in these animals that the absorption of extravasated blood is attended by so marked a degree of febrile reaction. If in guinea-pigs, inoculated with tubercle some three weeks previously, an artificial simple fracture or subcutaneous hæmatoma is produced, an intense reaction occurs (Schnitzler and Ewald).

I mentioned before how markedly tubercular patients react after surgical operations. In the light of these experiments, is it not conceivable that the true explanation of this fact lies in their special susceptibility to the absorption of albumose?

I have not, I fear, made this last portion of my paper very clear, but the facts are gathered from a number of different observations, all of which are not easily brought into a single line of argument. What I have attempted to show is:—

(1) That albumoses are found in blood clot.

(2) That they are all actively pyogenic substances, whether they are produced by the action of micro-organisms, or by the digestive or tissue ferments.

(3) That tubercular subjects react to the injection of albumoses, to the absorption of blood clot, and after surgical operations to a more marked degree than do healthy folk.

(4) To consider briefly the last hypothesis—that after simple fractures it is the absorption of fat that causes the pyrexia. In 42 per cent. of such cases fat has been found in the urine by one observer, while in a few instances Mr. Horsley found it in the sputum. These observations have not been confirmed and the proof that fat absorption can produce fever is altogether wanting.

III. "Aseptic" traumatic fever is seen under the following conditions:—

(1) After aseptic surgical operations.

(2) Following bruises and simple fractures.

(3) After burns and scalds.

(4) After head injuries; and

(5) After the passing of a sound or catheter.

In attempting to find in what proportion of cases this fever follows operations, I took any morning temperature above 99° as abnormal, if before the operation a normal temperature had been the rule. I excluded any case in which there was any evidence of bronchitis following the anæsthetic or in which the condition of the wound was in the least degree suspicious. I did not, for example, consider the fever which occurred after an operation for the radical cure of inguinal hernia as wholly aseptic, when it is stated some ten days later that "the wound is granulating up well and primary union has set in." In 1900, of all the operations performed, in 244 this aseptic fever occurred. I have tabulated the figures for some of the commoner operations—

	Total number.	Cases in which "aseptic" fever occurred.
Amputations ...	104	15
Radical cure of hernia	125	63
Laparotomies ...	116	17
Varicocele	59	12
Excision of breast ...	50	20
Osteotomies ...	35	9
Tuberculous glands	41	13
Excision of joints ...	15	4
Thyroidectomy ...	10	5

I do not know that the figures allow of very much remark. Taking an average, just a fourth of the total number of cases operated upon (including the few that suppurated) exhibited this aseptic fever.

Coming now to injuries, I have notes of twenty-one cases admitted in 1900, where extensive bruising was followed by a pyrexia. This was particularly well-marked in those cases when the abdomen or the face were affected. For example, in a patient under Mr. Golding Bird, a large hæmatoma of the face caused a temperature of 103·4°, which appeared twelve hours after the accident and lasted for three days. In a similar case, where extensive bruising of the abdomen occurred, in twelve hours the temperature was 103·2°. That the injury here was of no grave character, is shown by the fact that the temperature fell again in twenty-four hours and the patient went out quite shortly.

I found that out of 407 different fractures admitted in 1900, 113 were followed by some fever, *i.e.*, rather more than a fourth of the total number. Mr. Victor Horsley's figures show a somewhat larger proportion; out of 168 simple fractures of the long bones, in 91 a definite febrile reaction occurred.

The best marked temperatures are, as a rule, I think, in cases of fractured femur. Chart V. is taken from such a case and shows a fever of eighteen days' duration, which on two occasions reached a temperature of 101°.

With regard to scalds and burns, it is difficult to say how much of the subsequent fever can be regarded as "traumatic," as in so many cases suppuration occurs to a greater or lesser extent, and it is not easy to say when the simple passes into the septic fever.

In a few cases one does, however, see charts showing a typical simple fever. In one, of which I have record, the temperature rose to 101·4° in twenty-four hours, falling to normal again by the third day. It has been shown that the juices of burnt tissues are highly toxic in character and resemble in their effects, when injected, the toxalbumins produced by the growth of micro-organisms. They, too, probably belong to the same group of substances, which have already been shown to be so extraordinarily pyrogenic, viz., the albumoses.

So far I have considered the fever arising after aseptic operations, after subcutaneous contusions and fractures and after burns. I would briefly mention now two further varieties of traumatic fever which I would place quite apart from these, because they have so little in common—I mean the pyrexia that is so often observed after concussion and that which follows the passage of a catheter. The fever we have so far described, could be best explained as due to the absorption of extravasated blood. That to which I would now direct your attention, is, so far as it is "aseptic" at all, to be put down to nervous causes, either to direct irritation and upset of the thermal centres or to the stimulation of peripheral nerves.

In seventy-seven cases of concussion that were admitted into this Hospital in 1900, fifteen had a marked pyrexia which occurred from six hours to four days after their accident. The fever accompanies the stage of general reaction and must be ascribed probably to the hyperæmia of the brain following the anæmia caused by shock.

If the injury produces greater damage than a simple concussion, *e.g.*, a subdural hæmorrhage, this may directly affect the heart centres, and in such a case the temperature was 106·2° twenty-four hours after the injury.

With regard to the fever which follows the passage of a catheter or sound, it is exceedingly difficult to say, from the records of cases, how far the older theory, that it is due to a reflex congestion of the kidneys, can hold good, or whether it must rather be considered a septic fever, due to absorption from the urethra, and then find no place in this paper. Mr. Reginald Harrison is of this latter opinion. A case, however, like the following is difficult of explanation on this view.

In a middle-aged man, who had a stricture of some years' standing, and on whom an instrument had been passed on several previous occasions, an attempt to pass a sound was made without an anæsthetic. As this was not immediately successful, it was abandoned. Next morning, his temperature was 104°, and he passed only a small quantity of urine. Twenty-four hours later he died. At the autopsy, there was intense congestion of both kidneys, which were otherwise quite healthy. There was no cystitis, and no abrasion of the urethral mucous membrane.

IV. Aseptic traumatic fever often simulates, or is complicated by one of the infectious fevers. That patients who have just had a surgical operation are particularly susceptible to scarlet fever was observed years ago, and in a single volume of the Hospital Reports (1879) there are two papers on this subject—one by Mr. Howse, describing an epidemic in Astley Cooper Ward, which occurred the year previously, and another by Mr. Paley, on twenty-five cases at the Evelina Hospital. Mr. Thomas Smith records ten cases of surgical scarlet fever out of a total of forty-three lithotomies in children.

A scarlatiniform rash after operations may be one of four things. (Hoffa):—

(*a*) A vasomotor disturbance arising from nervous irritation.

(*b*) A toxic erythema, from the absorption of the products of a blood effusion, or of antiseptics.

(*c*) It may be an accompaniment of septicæmia.

(*d*) It may be a genuine scarlet fever.

After burns true scarlet fever occurred in four out of a total of 224 cases (F. E. Walker).

Whether the infection enters through the wound, which would thus allow a larger quantity of the poison to be absorbed than is possible through the ordinary channels—an hypothesis, which would account for the shorter incubation period that distinguishes surgical scarlet fever from the common form—or whether the patient had the infection before the operation, which only serves to accelerate its development, appears to be a point still under discussion. Certain is it, that oftentimes the rash commences at the edges of the wound. A little girl, for instance, falls down and cuts her forehead against a projecting piece of furniture. The wound is cleaned, united with sutures and heals by primary union. The same evening the edges of the wound are noticed to be swollen and her temperature rises; on the following day she is covered with a scarlatinal rash and this disease runs its usual course. In one case, occurring during the epidemic of fever at the Evelina Hospital, the patient died thirty-six hours after the operation without developing a rash.

A girl had both internal recti muscles divided for an internal squint under chloroform at 1 p.m.; in twenty-four hours her temperature was 102° and in thirty-six hours it had risen to 104·6°, when she died. At the autopsy nothing was found to account for her death.

The same relation would appear to exist between traumatic fever and measles and influenza. In 1898, during an epidemic of the latter in New York, an American surgeon records several cases of temperatures of 104° to 105° occurring directly after aseptic operations, which fell almost immediately, and which he attributed to the prevalence of influenza.

With traumatic fever is associated occasionally a traumatic delirium, although this may occur without any pyrexia. I have found five cases, where the two conditions occurred together after fractures, and saw another one quite recently. This was a case of a Pott's fracture, where, forty-eight hours after the injury, the temperature was 101·4° and the patient was loquacious, attempting to get out of bed and to pull off his splint. I imagine the association of these two is nothing more than a coincidence, and beyond the fact that the injury is responsible for both of them, they have no causal relationship.

V. To come to the last part of my subject. What is the significance of this fever? As a rule it has little and disappears with the exhibition of a brisk purge. On the other hand, it indicates, as a rule, that some post-operative oozing has occurred and that there is some effused blood being absorbed. This will form a fine medium for the multiplication of micro-organisms and will so predispose

to suppuration. This point is exemplified by a glance at Charts I. and IV., in both of which the traumatic pyrexia was well marked and in both of which suppuration occurred.

With regard to its prevention, Professor Tillmann recommends—

(*a*) In the first place that no antiseptics be allowed to touch the cut surface of the wound, as they will cause by their irritation blood extravasation. He says that, since he gave up the use of carbolic acid and hyd. perchlor., he has never had a case of traumatic fever. To attempt to show the influence of the use of antiseptics, I collected all those cases on which an operation for the radical cure of an inguinal hernia was performed in 1900, and which ran an absolutely aseptic course. Out of a total of 103 of such cases, some fever occurred after the operation in 63. When antiseptic dressings and lotions were used the pyrexia was noticed in 71 per cent. of the cases, while in those instances where sterilised pads replaced antiseptic gauze and where a greater reliance was placed on asepsis rather than on antisepsis, this fever was found in 54 per cent. No value, I think, can be attached to the difference between these figures as in no case was antisepsis absolutely excluded.

(*b*) That the time during which the wound is exposed to the air be curtailed as much as possible.

(*c*) That drainage be provided where it is necessary, and that any tension of the wound be avoided.

(*d*) That after the operation, the elimination of anything absorbed from the wound be encouraged by giving laxatives and copious enemata of warm water, and by leaving, after intra-peritoneal operations, some sterilised water within that cavity.

Reviews.

The price of books submitted for review should in every case be stated.

International Directory of Laryngologists and Otologists. Compiled by Richard Lake, F.R.C.S. Second edition. (Rebman, Ltd.). 5s. nett.

The title of this useful little book is sufficiently descriptive of its contents. Great pains have been taken to insure accuracy, and whilst the sanction of every specialist has been obtained before inserting his name, every effort has been made to render the lists as complete as possible.

Selected Essays and Addresses by Sir J. Paget. 10 by 5½, pp. 445. (Longmans). Price 12s. 6d.

This book consists of a series of twenty-four essays, some written for the medical journals, others for the lay magazines, but all intensely interesting. Sir James Paget must have been a man of wide sympathies and with many interests, such as is now rarely found in this age of specialisation. He ranges over the whole of medicine and surgery, and not content with these, discourses on "Theology and Science," "Temperance versus Total Abstinence," and these form two of the most delightful of the series. In a chapter on "The Use of the Will for Health," he illustrates the total indifference to pain of the uneducated mind, by a story of a Maori boy, who when presented with a pair of boots too narrow for his toes, promptly chopped off a slice from the inner side of either foot, covered the wound with dust, and wore the boots until the sores were healed.

Appointments.

CIVIL.

BATCHELOR, F. S., M.D. Durh., has been appointed Physician for Diseases of Women to the Dunedin Hospital, New Zealand.

MILITARY.

SURGEON-LIEUTENANT H. W. WEBBER, Second Devonshire Volunteer Artillery, has resigned his commission.

Births.

CARD.—On April 15th, at Muswell Rise, N., the wife of Alfred H. Card, L.R.C.P. Lond., M.R.C.S., of a daughter.

MARTIN.—On January 21st, 1902, the wife of Dr. Albert Martin, of Wellington, N.Z., of a son.

Marriages.

JEWELL—HUGHES.—On May 3rd (by licence), at Christ Church, Streatham Hill, by the Rev. C. S. Nicholl, Vicar, J. W. F. Jewell, M.D., M.S. Lond., of Oakmead, Balham, elder son of W. H. Jewell, Lyndhurst, Streatham Hill, to Marion, daughter of Thomas James Hughes, Llandaff House, South Road, Clapham Park.

ROBERTSON—PENMAN.—On April 28th, at Chatsworth Road Chapel, West Norwood, by the Rev. W. Armstrong, James Robertson, M.B. Lond., M.R.C.S., L.R.C.P. Eng., third son of Dr. W. B. Robertson, of West Dulwich, to Elizabeth Taylor (Bessie), eldest daughter of William Penman, Esq., Ardluis, Palace Road, Tulse Hill, S.W.

STAINER—WENDOVER.—On April 24th, at All Souls Church, Langham Place, W., by the Rev. R. Ross, Courtenay B. Stainer, L.D.S. Eng., only son of R. W. Stainer, 19, Clarendon Road, Southsea, to Alice Beatrice, eldest daughter of A. Wendover, Lynton Dene, Vanborough Road, Southsea.

Death.

BERRY.—On May 2nd, at 66, Pembridge Villas, W., Henry Thomas Berry, M.R.C.S., L.S.A., in his 83rd year.

ED.—D. G. G.

Contents.

	PAGE
Some Interesting Cases of Chorea: Clinic l Lecture by Dr. Fawcett	209-214
Details in Abdominal Section	214-215
A Case for Diagnosis	215-216
"Our Ancestors' Certain Cures"	216-217
A Sale of Work in Aid of Guy's Hospital	217
Notices	218
Correspondence: South African Memorial Fund ...	218
Passim	219-220
Duels Ancient and Modern	221-222
Prizes	222
To the Sex	222
In Lighter Vein	223-224
Pass List	224
Reviews	225
South African Memorial Fund: Tenth Subscription List	225
The Nurses in Fiction	226
Sport: Cricket—Guy's v. Beckenham; Guy's v. Blue Mantles; Guy's 2nd XI v. The pids	227-228

Calendar of Coming Events.

May, 1902.

Sat. 24.—Messrs. Symonds and Steward's take-in; Drs., H. E. Morris and W. H. Bent; Cl., W. G. Parker.
G.H.C.C., III., v. Christchurch Institute "A," away.
G.H.L.T.C., v. Gravesend, away.

Mon. 26.—1.15 p.m., Clinical lecture by Dr. Galabin.

Tues. 27.—G.H.S.C., Polo Match v. Barry, home.

Wed. 28.—1.30 p.m., Clinical lecture by Dr. Hale White.
G.H.C.C., I, London County, away.

Thur. 29.—Messrs. Lucas and Lane's take-in; Drs., H. M. Woodward and C. H. Dawe; Cl., C. Tessier.
1st Year's Dental Students' Clinical Exam. for Prize at 2 p.m.

Fri. 30.—1.30 p.m., Clinical lecture by Mr. Dunn.

Sat. 31.—G.H.C.C., I., v. Reigate Priory, away.
II., v. Hos.-Scho., home.
III., Camberwell House, away.
G.H.L.T.C., v. Wanstead, away.
Last day for sending in Fees and Certificates for the 1st and 2nd M.B. Camb. Exam.
1st and 2nd Years' Dental Students' Laboratory Exam. for Prizes, at 9 a.m.

June.

Mon. 2.—1.15 p.m., Clinical lecture by Dr. Perry.
July Appointment List opened.
Last day for applying to Registrar for form of entry for Pre. Sci. M.B. Lond. Exam.

Tues. 3.—Exam. for Treasurer's Gold Medals begin.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 4.—1.30 p.m., Clinical lecture by Dr. Hale White.
G.H.C.C., II., v. London Hospital "A," home.
Last day for names to be sent in for 1st and 2nd M.B. Cambridge Exam.

Fri. 6.—1.30 p.m., Clinical lecture by Mr. Dunn.
G.H.S.C., Polo Match, v. Grafton, away.

Sat. 7.—G.H.C.C., I., v. R.I.E.C. Cooper's Hill, away.
II., v. St. Bart's "A," home.
III., v. New Eltham, away.
G.H.L.T.C., v. Blackheath "A," away.

Guy's Hospital Gazette,

MAY 24, 1902.

Some Interesting Cases of Chorea.

CLINICAL LECTURE BY DR. FAWCETT.

January 26th, 1902.

Gentlemen,—The case I propose to bring to your notice to-day is that of a man of 38 years of age, recently admitted into Clinical with what we diagnosed, for want of a better name, as "adult chorea."

This case, with others, I shall mention later, will serve as instances of some interesting varieties of chorea seen in the hospital at different times. For the careful report of our patient I am indebted to Mr. J. A. Butler.

In the previous history, there are one or two points of interest. His father died at the age of 60, of heart disease, having had rheumatic fever at about 35 years of age. There is no history of rheumatism in the family except this, nor of functional nerve disturbance of any kind. The patient himself contracted syphilis eight years ago, for which he underwent three years' treatment. He has never had chorea or acute rheumatism. There is one other interesting feature in his history, namely, that his wife is now in an asylum, suffering with General paralysis of the Insane. He has been married for four years, and the illness of his wife has worried him very much.

The history of the present illness is given as follows:—"About seven weeks ago he caught a severe cold through getting his shoulders wet. He had running from the nose, and a cough, and this was followed by pain between the shoulders and in his right leg, which he describes as being like "rheumatism." "The pain shortly afterwards left his shoulders and leg, and settled in the back of the neck. It was of a dull, aching character, coming on at intervals, and then disappearing altogether for a time. The pain has now left the neck,

and is felt in the left parietal region." He did not complain of any pain on admission to the hospital. The first thing he noticed in connection with his present symptoms was a difficulty in using his right hand to get change out of his pocket, and in writing his way bill—he was an omnibus conductor—also that his speech seemed altered. The next thing was loss of control over the movements of right leg, and pain in the right buttock of a dull, aching character. The remainder of the right portion of the body has not been affected. He has had no difficulty in micturition, his bowels have acted regularly.

The motor power is good and equal on both sides, as measured by the dynamometer, but on the right side the grasp of the hand is not maintained, it having a tendency to relax and then to contract again as strongly as ever. Mr. Butler states that there is no paralysis. I shall have something to say about this later.

The character of the movements is described as irregular, jerky, involuntary, choreiform in type, affecting the right arm and leg and occurring on attempts being made to use the limbs, but with very little movement when the limbs are at rest. On trying to use the right hand the right leg moves irregularly also. The tongue shows irregular jerky movements, and projects slightly to the right when protruded. Articulation is jerky and not well under control. There were bilateral facial movements, but no nystagmus. On walking the patient distinctly drags his right leg, and it seems to be a little weaker than the left.

The knee-jerks and plantar reflexes are described as exaggerated on both sides. The pupils react normally. There are no trophic or sensory changes, no affection of the special sense organs, of the bladder or the rectum. There was no rigidity and no lead line on the gums.

Nine days after admission the patient's condition had so much improved that he was able to write his name legibly, and the only movements noticeable were occasional ones on the right side of the face and the right side of the body.

He was discharged to a convalescent home eighteen days after admission, showing then only slight twitching movement of the right side of the face. The tongue still protruded rather to the right.

The chief interest of the case depends on the fact that we came to the conclusion that the case was one of Chorea, despite the patient's age and that he had never had a previous attack.

The sudden jerking, involuntary, irregular movements were very characteristic, and with these there was some degree of muscular weakness in the extremities and face of the right side.

There were, however, bilateral facial movements.

Now, with this hemiplegic distribution the question at once arose whether the case was really one of Chorea, or whether some other functional disturbance or organic lesion was the cause of it.

I therefore propose to run briefly through the conditions which were discussed and which were ultimately put aside, leaving the diagnosis as I have already mentioned.

Gross lesions of the brain have occasionally occurred in cases of chorea due to embolism of a large artery, but these are followed by a definite hemiplegia, which was not present in this case. Then there are the disorders of movement occurring in connection with hemiplegia. They usually take on the form of tremor of an irregular, but sometimes of a rhythmical type, of occasionally a rapid rate but more often slow, but in all such cases the contractions follow the return of voluntary power in the limbs.

Again, the condition is more often one of spasm varying in degree in different muscles and the movements are slow and irregular with usually some rigidity of the affected limb. Rigidity was not present in this case.

Occasionally cases are met with in which such a form of "mobile spasm" gradually appears without any preceding hemiplegia, and such were designated by Hammond as "athetosis." The spasm is similar to that mentioned in the hemiplegic cases, affecting the arm more than the leg.

The face is not affected by the "mobile spasm," except that on movement the degree of

it is greater on the affected side. Now in the ætiology of these cases the fact comes out that they most commonly occur in cases of cerebral softening following some vascular occlusion, such as might have ensued upon a syphilitic endarteritis, and the question at once arose whether that was the explanation in the case before us.

But as I have told you, the movements were not subsequent to a hemiplegia, and their character was quite unlike the cases of "mobile spasm" following a hemiplegia or occurring independently of it.

The next question was whether the case could be one of choreoid spasm in association with a cerebral tumour. Gowers describes such cases as showing usually the same slow form of movement just described, or else movements of an irregular wild character as seen in insular sclerosis. This was not at all like our case, and in addition no general or localising symptoms of tumour existed.

Then again, the movements were not in any way like those of Insular Sclerosis, of lead or mercurial poisoning, or of the other well-known conditions associated with muscular tremors.

In so-called "hysterical chorea," the contractions are usually of a sudden shock-like character and more rhythmical than in true chorea. In this case the striking feature was the jerky irregularity of the movements and therein lay its chief resemblance to the true "Chorea." There were no hysterical manifestations whatever.

The last condition discussed was the possibility of the case being one of Insular Sclerosis in an early stage of development. The early manifestations of this disease are at times very indefinite, few or none of the classical symptoms being present and it is often impossible to classify them for the time except under the heading of "functional" disease. In this case there was no evidence of such a lesion, and I only mention it to you to warn you not to be in too great a hurry to diagnose as "functional" or "hysterical" any nerve condition which does not, more or less, conform to a definite type of organic disease.

Chorea occurring in adult life is a rare disease. There are two varieties of it usually described—

(1) Huntington's chorea in which there is a strong family history of the disease—a progressive mental deterioration, and a persistence of the symptoms.

(2) Adult and senile chorea—where, according to Gowers, the cases may be placed in two classes according to their course. In the one class the symptoms pass off as in the juvenile cases, in the other they persist, the latter being the most common.

The disease is less frequently met with between the ages of thirty and forty than any other, and although adult chorea more often appears after fifty years of age, yet it may commence earlier in the prematurely degenerate. This man had had syphilis—a disease which frequently leads to premature degeneration of organs or tissues. He looks ten years older than his age. The characters of the disease in our patient were the same as those of the juvenile type. It is interesting to note, however, that they differ from it in the absence of a rheumatic history. In this case, as a possible exciting cause, there was the worry occasioned by the illness of his wife, and in some others a history of shock or anxiety has been recorded in association with the development of the disease.

I propose now to turn to several cases of Chorea of interest, either because of the complications which ensued, or because of their gravity.

The *first* is that of a patient in whom chorea developed during pregnancy. As you know, these cases are always very anxious ones. The patient was twenty-one years of age, and two years ago she had somewhat marked anæmia. She was peculiar in her ways during this attack "throwing herself about." A year ago a similar attack occurred during which she became very much excited. She has now been married four months, and the report states that "she has been pleased with the idea of being pregnant." The illness commenced fourteen days before admission, and recently the movements had become so violent that she had to be "tied" to the bed.

On admission the patient was in a semi-conscious condition and the movements were extremely violent. Shortly afterwards she aborted, and the fœtus was considered to be one of three months. The patient rapidly became worse and died two days later, the temperature having risen to 105° on the evening before death.

Now Chorea occurs, as you know, as a complication of pregnancy. There was no previous rheumatism in this case, but there is occasionally, as in a case related by Gowers, where the first pregnancy was passed through quite satisfactorily, but between this and the second, the patient had an attack of rheumatic fever, and during the second pregnancy she suffered from chorea. As a rule there is nothing but the pregnancy to account for it.

I told you that our patient was twenty-one years of age, and Chorea in pregnancy hardly ever develops in a person who is over twenty-five. It much more often occurs in the first than in later pregnancies; it sometimes develops in the second, but it is very rare in later pregnancies.

The third month is the most common time for it to commence, although it may develop in any month, but the frequency becomes relatively less as the period of pregnancy increases, and it very rarely indeed develops, as late as the ninth month. This patient instances the above points very well, for as I told you, the fœtus was just over three months.

The ætiological relation of emotion to the disease is an interesting one. Sir Samuel Wilks noted that a large proportion of the cases occurred in unmarried girls, and in such the excitement produced by the discovery of the pregnancy will in most cases be the more marked. The prognosis is in all a serious one.

In the ordinary cases of chorea, not more than 2 per cent. of the patients die, but according to Gowers, in the cases of chorea with pregnancy, 20 to 25 per cent. die. The immediate causes of death are not very easy to determine. In this patient it was partly due, no doubt, to the effects of the exhaustion from the severe movements, and from inability to take or retain food, either when given by the mouth or by enemata. To this is added the effect produced by abortion or delivery occurring in an already exhausted subject.

The *second* case of Chorea is one in which there was very marked muscular weakness of the left side. The patient was a child, nine years of age, and a female. She had had no previous attacks, but a month before admission she had twitching movements on the right side, which gradually affected the right arm and leg, and then spread to the left side, and later, to the left leg. Fourteen days before admission the child became unable to walk. The report states :—"There is no history as to when the left arm became powerless." That I want you to note. "For some days there has been some pain and swelling in the ankles and feet. On admission, there were typical choreiform movements on the right side, but the left arm and leg are quite motionless. She can grasp anything with the right hand, but there does not appear to be any power to do so with her left." Moreover, there was a doubtful weakness on the left side of the face. There was an apical systolic murmur present. Six days after admission the child began to recover power in her left arm, and in six weeks was quite well.

Now there is usually some deficiency of muscular power, more or less marked, in cases of Chorea, the arm being usually most affected, or the arm and leg on the side, as in this case, that is to say, it is either hemiplegic or monoplegic in distribution.

The important point about this weakness is, that it comes on gradually. You remember the report stated that it was not known when the loss of power came on. There are some cases in which this loss of power is the only marked feature of the case, and you can understand how difficult the diagnosis may then be. They are described as cases of "paralytic chorea," they usually occur in children, and if the child has been under careful observation throughout, you may be able to obtain some history of slight twitching, which have been noticed about the corners of the mouth, or of the hands, or you may detect it on careful examination.

The *third* case is a very rare one in which a state of wild and violent excitement developed,

followed by convulsions, and the death of the patient. She was a female, twenty-three years of age, and was admitted on the 27th April, 1899. She had previously had attacks which were described as hysterical and which left her much exhausted. Four months previous to admission she had had rheumatism, and from the description given it was almost certainly of the acute rheumatic type. Two months before admission twitchings began. One month before admission she married, and almost directly afterwards had to nurse her husband, who became seriously ill with pneumonia. This increased strain upon her powers caused the movements to become much more marked. The description of her condition on admission is as follows: "The hands are never still and the face is continually moving." Two days after admission the movements became much more violent and continued so up to May 12th. She also began to suffer from delusions. The movements were generally noted to be more violent during the night than in the daytime. After this date the condition of the patient varied very much, being sometimes better and sometimes worse. At times the movements became so violent that it was necessary to administer chloroform. She was unable to take any food by the mouth. An extremely excitable mental condition persisted throughout the attack. She was at times maniacal. Some two or three days before her death she became much more noisy and restless, shouting and talking, and the movements became more marked. On June 7th she had three "fits," in the last of which she died.

Here, then, we have a patient of very excitable temperament, who had had rheumatism. She married after the Chorea had commenced, and in addition to this her husband shortly developed pneumonia. It is not surprising, therefore, that in a patient of so excitable a disposition, the result was a very severe attack of Chorea. Cases of this class are rare, and the prognosis is generally bad, and as in this case the more marked the mental distubance the worse the prognosis.

Most of these cases occur in women, and the mental disturbance may come on previous to the Chorea, or as in this case after the chorea has started. In some of the cases the mental disturbance is so marked that the patients get into asylums without the chorea having been recognised at all. You often see more or less mental disturbance, *e.g.*, a man is dull, or a child is dull, or excitable, or depressed. But it is very rare to meet with cases with such severe mental symptoms as in this one, except, in asylums, and here even they are rare.

The last case that I propose to take is that of a boy eleven years of age. He provides us with a good example of the association of chorea with rheumatism and endocarditis. Two months previously he had had rheumatic fever, followed by a relapse. On the day before admission the mother noticed movements of his left hand and mouth, and also that he was constantly dropping things. His temperature was 102·2°, he had general and typical choreiform movements most marked on the left side. The heart was dilated and with well-marked mitral stenosis and regurgitation present. Seventeen days after admission a rheumatic nodule was found on the left elbow. Three days before this the patient's temperature rose to 101°, and the rise was associated with general perspiration and pains in the shoulder joints. The temperature had previously been normal for ten days.

The sequence of events was then as follows, a definite attack of acute rheumatism followed by a relapse, and then by chorea, and finally while the chorea was running its course further evidence of the rheumatic poison was manifested by the rise of temperature, the joint pains, and later the formation of a rheumatic nodule.

Now, this association of chorea with rheumatism is one of the first things that you hear of when you go into the Medical wards, and you will find that in about one-quarter of the cases there is a previous history of acute rheumatism. But in this twenty-five per cent. the age of the greater number is more than ten years, while under ten years of age you do not get anything like such a proportion of patients who have previously had acute rheumatism. This boy was eleven.

In this case the valvular lesion was undoubtedly due to the preceding rheumatism, and in many others it is probably antecedent to the

Chorea, for evidence of enlargement of the heart with well developed murmurs is found, even in cases where the duration of the chorea is quite short. Where heart disease exists it has frequently preceded the chorea. In other cases the organic murmur has been observed to develop during the course of the chorea.

The most important point for you to remember is that in these latter cases the endocarditis is usually of a benign type, and that in some of the cases the localisation of the murmur to the apex, or to some other position not characteristic of organic murmurs, renders the diagnosis of organic disease uncertain for a time; but according to various statistics, about nine out of every ten fatal cases of chorea show evidence of endocarditis, it is most important for you to be alive to the possibility of a localised murmur indicating the presence of organic disease, and not merely due to a co-existing anæmia, or other temporary condition.

There are still many points I should like to have touched upon in connection with the cases I have related to you, but as I see my time is over, I must leave these for another occasion.

Details in Abdominal Section.

ON arrival a hot bath is given, and confinement to bed beforehand is not insisted upon. Overnight two pills of Colocynth and Calomel are given, with an enema of soap and water in the morning; if there is great distension or constipation, half-an-ounce of turpentine or castor oil is added to the enema. If the operation is at two no food is given after ten a.m. Overnight a compress made of boiled lint in Perchloride of Mercury is applied to the abdominal wall, which is well washed with soap and water, scraped with a razor; the pubic hairs are cut down to lower border of the pubic pad. Liquor Potassæ. or Ether is usually used to remove the grease before applying the compress; a scrubbing brush is rarely used.

If the operation involves the uterus a douche of Perchloride of Mercury is given one hour before the operation, and a catheter, previously boiled, is passed after rubbing the urethral orifice with Hyd. Perchlor. (1–3000), or a one per cent. solution of Lysol. In malignant growths formalin douches are more usual.

The operation usually lasts from one hour to three. If it lasts one hour little treatment is required. The average abdominal section takes one and a half and upwards.

A saline injection (℥i.–Oj.) of a pint is frequently given with a soft catheter before the return of consciousness; it is advisable in any case where the operation has lasted more than an hour, or if there has been any hæmorrhage.

If the patient is robust and the operation not unusually severe, no food is given for twenty-four hours at all, but a copious supply of fluid is ensured by sips of water, hot or cold, soda water, rectal injections and subcutaneous injections, or transfusion into a vein. A drachm to a pint is used for the tissues and alimentary canal. A drachm and a half for intravenous injections.

For the first twelve hours half-ounce doses of water or soda water. If the sickness subsides fluid by mouth is freely allowed. If there is reason to suppose that the patient is exhausted, nutrient enemata of the usual formula (see Pharmacopœia) of half a pint every six hours, or four ounces every four hours alternately with suppositories are given. As soon as the sickness has abated, which usually occurs in twelve to sixteen hours, drachm feeds of peptonised milk or albumen water are given every hour, gradually increasing to ℥v. feeds every two hours. On the evening of the second day, or morning of the third, calomel, mag. sulph., liquorish powder, castor-oil, sennæ and sulphur, or a purgative enema is ordered. The bowels are opened on the third morning. If not sick or distressed, custard, tea, bread and milk, egg and milk are given on the morning or evening of the second day. In a good case, the ordinary farinaceous diet, with fish and chicken, is given on the third day after the bowels have acted, and any agreeable diet without restriction on the fifth day.

A common plan is calomel on the second night, and a large oil and soap enema on the morning.

The patients are kept on their backs after the operation as a routine till the third day, when they may be rolled on to the side.

The catheter is usually required eight-hourly for about sixteen to twenty-four hours after the operation.

The slops that are given on the second to third day include Valentine's meat-juice, beef-juice (clinical prescription), and the several patent foods, *e.g.*, Allen and Hanbury's, Brand's essence, Plasmon, Somatose, Bovril, etc. Jelly and custard are also allowed.

A gentle douche of boracic, formalin, or chinosol is often given to every hysterectomy, but this is a matter of judgment. A fair proportion give rise to no more treatment than the above, no morphia is given, and no flatulence occurs. The stitches are removed on the tenth day at the first and only dressing. They lie in bed three weeks and are gone in three weeks and five days, some earlier, some later, each wearing one of Messrs. Downs' Hospital belts, and they return to be seen in three months from the operation, and are held to be ready for light work without lifting at the end of three months from the operation, and for ordinary work at the end of six, and to be normal in a year. Suppuration and hernia are alike rare.

Deviations from this uneventful path are common and for the most part transient; as in all operations, the commoner details, apart from operative failures, that

present themselves for consideration are: Persistent vomiting—Pain—Sleeplessness—Collapse and shock—Flatulence—Retention and constipation—Hæmorrhage—Peritonitis—Thrombosis and embolism.

For *persistent vomiting*, nutrient enemata with no fluids by mouth often answers; large draughts of soda-water Oss. followed by Oss. if the fluid is returned often brings away green acrid fluid with decomposing mucus, after which the vomiting may cease. Washing out the stomach, if skilfully done, is not embarassing and often instantly alleviates the retching,

Champagne, iced or not, iodine water, oxylate of cerium and many others are used, but are not so effective, as may be gathered from the long list of alternative treatments in which these remedies figure.

For *pain*, morphia is the best, but is not usually required in abdominal section, and the patients do better without it.

The pain in gynæcological operations is often intense in the small of the back, probably a referred pain due to the cervical nerves and irritation after incision into the dorsal. It is often palliated by a hard pillow in the hollow of the back. It is frequently due to straining and also to retention. It is not a common or urgent symptom as a rule.

Shock and collapse.—Shock is quite rare, even after the most prolonged and exhausting operations. Its rarity is notable and is probably due to the usual high temperature in the theatre; owing to bad ventilation the latter is always hot. Collapse apart from shock yields rapidly to the lavish administration of saline fluids. Pure shock is quite rare. Collapse from hæmorrhage and prolonged operation is also treated by injection of a weak solution of glucose into the subcutaneous tissue, this being but an experiment at present and not a routine or established treatment. Sugar is also used in the saline injections into the rectum. Transfusion has a powerful but evanescent effect, and if begun must be continued.

Sheep's serum heated before use is of service, but not apparently of more use than sugar and saline, or sugar alone. Three pints are usually injected under the skin, if used at all.

Flatulence is common on the second day and later, and usually yields to calomel and turpentine, or a long tube may occasionally relieve it. Salol and Mag. Sulph. are also given. A stock mixture is of great service.

Essent. Zingiber Fort. ɱxx. or Tinct. Carminativa ɱv.
Spirit. Ammon. Arom. ʒss.
Sodæ Bicarb. - - gr.xx.
Sodæ Alba - - - ʒss.
Aquam Bullienten - ad ʒi. p.r.n.

Peritonitis and obstruction are usually heralded by vomiting lasting more than thirty-six hours, constipation, distension, sunken eyes and subnormal temperature, eventually rising while the vomiting persists. Most cases of persistent vomiting are due to peritonitis, which is not necessarily fatal.

Cellulitis and thrombosis round the stump, with adhesions, may cause intestinal obstruction and a localised abscess to pass unnoticed while the patient is being drenched with iced champagne to stop the vomiting.

Speaking generally, the most troublesome feature is usually prolonged vomiting, for which the tendency is to wash out the stomach, either by large draughts of soda or hot water, or by a stomach tube.

Pneumonia, pleurisy, and such sequelæ are excessively rare.

Chloroform is used entirely for nearly half the patients, for the rest, A.C.E. and ether about equally.

The above treatment will be found to be very simple, but the results may be said to be extremely satisfactory.

The use of sugar solutions may be said to be in its infancy, but it has probably a great future before it in collapse or hæmorrhage.

The dressings are entirely of sterilized gauze, and suppuration is very rare; the bandages are made of broad strips of strapping lying horizontally, the lowest, just above the level of the trochanters. These are firmly applied round the body, but not to the back, and answer very well. They are slit up on the tenth day for dressing, and pinned together afterwards. Sterilised pads are packed over, and a Domette many-tailed bandage pinned over. This bandage requires changing every four days. It answers better than a towel or any other application, as it practically never produces a sore back.

The above is merely detailed as a matter of fact, but we hope to receive many criticisms or experiences for publication.

Case for Diagnosis.

A YOUNG married woman, æt. 28, six months pregnant, was admitted on a letter describing her as suffering from "peritonitis." It was a normal history till two days before admission when a slight pain in the abdomen gradually developed into severe pain, for which she took to her bed.

She was a dark, slender, well-nourished woman, looking fairly well. Pulse 132, respiration 20, and temperature 99·2°. She complained of great pain in the abdomen, and localised it along the borders of the pregnant uterus in a horseshoe shape following approximately the course of the large intestine, which was greatly distended, tympanitic, and in which some peristalsis could be made out, or at least was sacculated in form. No flatus or motion had passed since the attack of pain. The vagina was normal and the rectum contained one marble scybalum, the os was the size of "fourpence," the internal os was flattened, the membranes were very tense and bulging, there was no sign of labour; ballottment easily obtained. The fœtal heart was heard with some difficulty. There was no bleeding, the history of six months' amenorrhœa was clear, and the periods previously had been quite regular. The intra-abdominal pressure was clearly high and the walls were

somewhat rigid though not naturally very flattened. The uterus was the size of six and a half to seven months, but its upper margin was somewhat obscured by the abdominal distension and tenderness. A provisional diagnosis of peritonitis was made, but operation was not held to be imperative. She did not look very ill, but the pulse was quick and not due to excitement, and there was some sinking of the eyes, a dark-brown furred tongue and she had been sick once. In the ward during the next sixteen hours she vomited three times, due probably to the treatment which was adopted. Except for colicky attacks she remained fairly quiet, but her pulse was no better next day. There was no sign of labour, the membranes were still tense, the uterus not displaced. The bowels had been relieved by a powerful enema of about six small scybala, some flatus, and apparently intestinal obstruction no longer need be considered.

The tenderness was still as striking if not increased and she had vomited in the night three times, each time on exhibition of calomel; the vomit was not fæcal but undigested food chiefly. She hardly slept. The tenderness was more on the right side along the ascending and first half of the transverse colon. The distension increased in spite of turpentine enemata. On the third day the temperature, which had been 99·2°, fell to normal.

(For Solution, see p. 228.)

"Our Ancestors' Certain Cure."

TO-DAY I was rummaging in an old iron-bound trunk, which I had always been told contained nothing but rubbish, and though at first sight such a condemnation seemed justifiable, I was rather inclined to seek to the bottom, led on at first by a smell of old leather, and then by the sight of a fat, well-bound volume. It was venerable, of that there was no doubt, but yet in a state of good preservation; its s's were f's and its spelling was quaint. I hailed it with joy; at home all our books are new, our house is essentially up-to-date in literature, and we spend so much more money on magazines and weekly periodicals, which to-day are, and to-morrow are given to the hospitals, than on those which may last a lifetime, so much money in the lending libraries, and so much time at the free library, that I felt glad to hold this old volume in my hand and reflect that it might have been written before all these arrangements existed.

The book has been well used, many favourite passages appear to be marked, some leaves are turned down (even our ancestors had these bad habits), there are spots which I must suppose are mildew (they look remarkably like grease), but this is by way of a cursory glance; now for the title, have I found a treasure in homilies, a book of philosophy, or a gem of general knowledge? Neither.

"The Britiſh Houſewife by
Mrs Martha Bradley late of Bath

being the reſult of upwards of thirty years experience. The whole (which is deduced from practice compleating the careful reader from the higheſt to the loweſt degree, in every Article of Engliſh houſewifery."

To which are annexed—

"The *Art of carving* and the polite and eaſy manner of doing the Honours of the table. The *conduct* of a Family in reſpect of health, the diſorders to which they are every month liable, and the moſt approved remedies for each."

This latter sentence rouses my curiosity; the month was now March; what disorders ought March to produce? Supposing violent symptoms were to exhibit themselves at once, would it not be better to be armed with a remedy? I turn to the index, it appears to be a thing apart, it certainly bears no relation to this volume, no doubt the index to this is in some other one. Unique idea but not helpful, however, I search through a few of its five hundred pages. It is a little bewildering, there is as great a variety of subject and in about the same order as a dictionary. Mrs. Martha Bradley appears to have dotted down recipes, advice prescriptions, pretty well as she thought of them, and the publishers haven't seen fit to sort them out.

From the recipe of "preparing Veal elegantly as a Raggoo" we fly to gardening advice, and on the same page that I learn how to make "roapy beer" there is a prescription for "Lady Allen's Gaſcoign Powder." You must have it, I feel that like "Sapolio, no household should be without it."

"Two ounces of the Eyes of Crabs.
Crab's claws two ounces and a half.
White Amber and Pearl, of each half an ounce.
A ſtiff jelly of Hartſhorn to be coloured with Saffron to the Height of a deep Seville Orange, make it into Balls and ſet it by for uſe. This Quantity will be more than you can uſe in two Years." I feel sure it would last me considerably longer.

Next door to it there is such a universal cure that I must copy it down too.

"Take a peck of ſnails in the ſhells, and put them into an oven as hot as for cheeſe cakes" (after this I could never touch a cheesecake) "let them lie till they have done hiſſing; then take them out of the oven, pick them out of their ſhells and throw them into a little Beer. Take two Quarts of large red Earthworms, ſlit them up with a Pair of Sciſſors, put them into a Colander and ſtrew ſome Salt over them." I don't think I can continue such a harrowing record to the end, enough to say the Worms and Snails are strewn on a bed composed of no less than twenty different herbs and their sufferings finally ended by being covered by eight gallons of Ale and two Quarts of Sack. Many mysterious rites are performed in the way of boiling, distilling and placing in a Limbeck, whatever that may be. "When made this is an excellent Remedy for the Black or Yellow Jaundice, Cholick in the Stomach, Convulſion Fits, Swooning Fits, Small Pox, Measles or a Conſumption, etc., etc." We are told "only a ſmall Quantity at a time should be taken," this advice struck me as being unnecessary.

One prescription has a most delightful footnote. "N.B.—Lady Hewit fays ſhe had this receipt communicated to her, upon a promiſe never to diſcloſe it."

Oh! Lady Hewit, Lady Hewit, how have you kept that promise, we must suppose your desire to be a benefactress to the human race overcame your woman's sense of honour.

In these days of Sanatoria when people pay heavy fees and separate themselves from home and friends to become cured of Consumption, it is pleasant to hear how easily they used to manage these matters.

"Twenty garden Snails and the hinder legs of thirty frogs with a few more ingredients produces a very agreeably flavoured Broth, many have recovered from the Beginnings of Consumption by this Broth alone."

There are many of her prescriptions to cure apparently peculiar ailments which don't appear to be in fashion now, but the bulk of my nice fat old volume is occupied with cookery, pickling, preserving, brewing. It is all on a large scale. When Mrs. Martha Bradley sets forth to make a salad, she takes "A dozen Cabbage Lettuces and a dozen Cucumbers." A Woodcock Pie should contain at least "ſix Brace of Woodcocks or eight Partridges." She doesn't often condescend to mention the price, but here she tells us Partridges may fetch ten, fifteen, or twenty shillings a Bird.

To make A Tanfey. "Take a Quart of cream and twenty Eggs, as much Spinage as will give the Pudding a lively green, and as much Tanfey as will give it a ſufficient flavour, also a few Prim Roſe leaves."

A very economical recipe for Almond Pudding is one containing only twenty eggs.

Another delightful trait in this book is the Ambiguity of quantity; nowadays a good cookery book will tell one to a gill, how much liquid shall be used, or to a teaspoonful, or an ounce, how much of each ingredient; to a minute almost how long the things shall be cooked, but Mrs. Martha has a fine scorn for such details. "A Scallop of Rabbits" I learn is "A very elegant Diſh and a Favourite at many Polite Tables," it is composed of "Some young Rabbits, ſome gammon of Bacon, and a Raggoo of Veal sweetbreads, Cock's Combs, and Fowls Livers, with Muſhrooms, Truffles, Morels, and Veal gravy," then follow profuse but vague directions as to the further arrangement of the rabbits, but how the "Raggoo" is arrived at, and how many Cock's Combs, etc., are to be employed, is a matter for the imagination to deal with.

In the same way, we are told how to make "Elder Beer with ginger." We are to use "Two Bushels of Berries, which will be ſufficient for a year's uſe." Whether it will be sufficient for an army, a small family, or a single person, we can only guess.

But if there is a scantiness of detail, there is no lack of adjectives, a dish is described as being "Elegant, agreeable, exquiſite or genteel." Pike may be cooked in ſuch a way as to do Honour to the Politeſt Table, whilſt it may alſo be given to perſons of leſſ conſiderable means but no leſſ genteel;" one must never be content with merely placing bacon in a dish, it must invariably be "placed handſomely" or "finely." Though the greater part of the recipes and prescriptions emanate from Mrs. M. Bradley's pen, and are the result of her experience, yet many ladies of Quality have contributed, and even men have occupied their minds with these matters, we learn how "To make sausages Mr. Griſwell's Way," the directions appear to be a little more explicit, but the final advice is "You may eat theſe Sauſages as you pleaſe." The Lord Speaker contributes a prescription for "Cherry Water." Lord Conway, a baked Pudding, and The Lady Poly "a recipe for the Jaundice," whilst "The Lady Hewit's Cordial" contains no less than eighty-two ingredients, for the which she has obtained renown throughout the Country.

The Index speaks of a chapter on the manner and order of carving, which I fail to find, though in one place "The Maſter of the Houſe is eſpecially enjoined to keep the choiceſt morſels for himſelf."

There is very good advice on the doctoring of animals, not being a Veterinary Surgeon I am quite unable to judge of their efficacy. A layman, however, is advised to undertake an operation on cows for "Impoſthumations in the head." It is described in picturesque language with the usual want of lucidity, but we are told that "The Operation that appears ſo terrible to the Common Reader, is nothing more than what the Surgeons do to our own Species in trepanning." How exquisitely simple! Why should not every man be his own surgeon in future.

In one Recipe we are told that "it is a Receipt received the preſent Year, from the French King's Kitchen." That is the only clue I can find as to the age of the book or the era in which it was written.

Mrs. Martha Bradley may have been of valuable assistance to people in difficulties over the making of "cordials, clyſters, and cullifes," but I doubt whether she ever imagined she was providing as much amusement in the "Britiſh Houſewife" as I have extracted from my perusal of it.

L'INCONNUE.

Sale of Work in Aid of Guy's Hospital.

A Sale of Work, got up by Mrs. Percy Allan and a committee of ladies, was held in the Lads' Brigade Hall, South Croydon, on May 3rd last.

Mr. Cosmo Bonsor, who was introduced by Dr. Allan, opened the sale by giving a short history of the hospital and its work in the past; told of its falling revenues, and the efforts that have been made in recent years to put the charity on a sound financial footing. Mr. Bonsor, accompanied by Mrs. and Miss Bonsor, visited the various stalls, and made numerous purchases. The sale realised some £97, after paying all expenses.

Notices.

ROYAL COLLEGES OF PHYSICIANS AND SURGEONS.

Report, dated the 7th of July, 1885, of the Committee of Delegates, appointed by the Royal College of Physicians of London and the Royal College of Surgeons of England, to consider the question of the advisability and practicability of granting the title of "Doctor" to persons who have received the Diplomas of the two Colleges.

The Committee have to report that they have fully considered the question referred to them, viz., the advisability and practicability of granting the title of Doctor to persons who have obtained the Diplomas of the two Colleges.

They have also considered the Memorial, signed by more than 600 Teachers, Practitioners and Students in Medicine, and referred to them, advocating the amalgamation of the two Colleges into one Royal College of Medicine, for the purpose of granting degrees in Medicine and Surgery.

After careful deliberation, the Committee have unanimously agreed to the following resolutions as expressive of their opinion on the subject:—

i.—That it is desirable that persons examined by the Royal College of Physicians of London and the Royal College of Surgeons of England conjointly, and found duly qualified, should, in virtue of that examination, have a Degree in Medicine and Surgery conferred upon them.

ii.—That the curriculum of study and the examinations to be undergone for the License of the Royal College of Physicians of London and the Diploma of the Royal College of Surgeons of England are equal to those required by most of the Universities for Degrees in Medicine and Surgery.

In conclusion, the Committee are of opinion that, should the two Colleges approve the foregoing Resolutions, means could be found for giving effect to them.

WILLIAM JENNER,
7th July, 1885. Chairman.

As the above report makes our prospect of ultimate success more hopeful, kindly sign petition already sent, and return to Secretaries, 41, Devonshire Street, Portland Place, W. Fresh petition form will be sent on application.

BRITISH MEDICAL ASSOCIATION.

429, Strand, London, W.C.

GRANTS FOR SCIENTIFIC RESEARCH.

The Council of the British Medical Association desires to remind members of the profession engaged in researches for the advancement of medicine and the allied sciences that it is prepared to receive applications for grants in aid of such research. Applications for sums to be granted at the next annual meeting must include details of the precise character and objects of the research which is proposed, and must be made on forms to be had of the General Secretary, at the office of the Association, 429, Strand, W.C., on or before June 14th.

Reports of work done by the assistance of Association grants belong to the Association.

Research Scholarships.

The Council of the British Medical Association is prepared to receive applications for two Research Scholarships which are vacant, of the value each of £150 per annum, tenable for one year, and subject to renewal by the Council for another year.

Applications for Scholarships must be made on forms to be had of the General Secretary, and returned on or before June 14th.

FRANCIS FOWKE,
General Secretary.

429, Strand, May 13th, 1902.

Medical Department of the Navy,
Admiralty,
Northumberland Avenue, W.C.,
14th April, 1902.

An Examination of Candidates for entry into the Medical Department of the Royal Navy will be held on the 2nd June next and following days at Examination Hall, Thames Embankment.

Not less than Thirty Commissions, as Surgeon, will be offered for competition.

The forms to be filled up by Candidates will be supplied on application to this Department.

H. F. NORBURY, Director-General.

Correspondence.

To the Editor of Guy's Hospital Gazette.

South African Memorial.

Dear Sir,—I enclose 10s. 6d. towards the South African Memorial Fund.

Suggestions.—*Site:* The grass plot to the left of the Colonnade steps, the "memorial" to face the Dental School.

Form: A plain bronze pedestal, inscribed "To the memory, etc.," (in English) with some brief eulogy, such as "Loyal, loving and beloved, they honoured alike their country and their calling."

The figure mounted on the pedestal to represent a wounded soldier receiving from the surgeon such relief that both faces bespeak happiness, the one of giving and the other of receiving succour. Above this the Union Jack and Geneva Red Cross crossed and in between them the hospital arms and motto. Height not to exceed six feet; relative proportions as the artist advises.—Yours truly,

O. L.

Cheadle, Cheshire.

Passim.

The lethargic public is at length waking up to the importance of Research and there is some prospect of a considerable movement in the direction of endowment of Research in various forms, but it is not quite clear that the movements will not, like most popular commotions, rather fail through ill-directed energy. One hears of munificent donors, Guy's has been particularly fortunate in Mr. Robert Gordon, and of the association of great and honoured names, of the patronage of the Royal Colleges, but the reflection arises that truth is not found in such places, that discoveries are rarely made in the well-equipped laboratory by the prosperous expert, but more commonly in such a dingy cell as the room where Pavy conducted his renowned researches on diabetes, by the unknown and indigent scientist.

In the Universities of Cambridge, Oxford, and elsewhere, in Guy's, as at provincial universities, there is a plethora of highly equipped ardent scientists, whose honours entitle them to respect, and whose abilities are undoubted, but yet who every day retire from the pursuit of chemistry, physics, physiology, pathology, and the like, because their position is practically unpaid, and so far from realising affluence by their intellects, they have no prospect of even a competence in the future.

Physiology many a man has abandoned because it does not pay, and experimental pathology, the only hope of scientific medicine, lacks endowment, men, and material. In the University they have men, money, and equipment, but no material, and their resources are limited. In London they have abundant material, but there it ends. When one thinks of the enormous field for research afforded by one's own pathological records, and of the vastness of the field to be included, if one does not wish the part to be mistaken for the whole and misunderstood, the opportunities for research seem unlimited.

The vision that appeals to one is that of the Physiological Laboratory, full of men, learned in science, art, medicine, physics, and above all in physiology and chemistry, with the co-operation of the Physicians and Surgeons, and abundant means, striving to discover new remedies to reconcile conflicting evidence, and to attempt fresh cures on the lines of a past experience. When Bright had the entire use of Clinical, all cases of albuminuria were set apart for his investigation, the results of which were magnificent.

If cancer is ever to be tackled with fair prospect of success, it will be by grouping the cases together, classifying and investigating, but unless the discovery of the truth is to be a mere accidental observation, like the Röntgen Rays, the observers must have intimate acquaintance with human physiology, with bacteriology, toxin and antitoxin, and be able to test every observation chemically, bacteriologically, and practically.

To put it briefly, the investigation must be clinical but scientific, and the investigation must be by a scientific organisation, not in part by the bacteriologist, in part by the morbid histologist, and summed up by a practising physician. What we feel is wanted is a powerful organised band of researchers, under a thoroughly fine organiser, to collate, harmonise and direct the enery that is so often misspent.

We have great pleasure in congratulating Mr. C. H. Fagge, on his appointment as Surgeon in charge of the Ear Department, and in approving heartily of the policy that is inaugurated thereby of making the post one to be held in addition to the ordinary appointment held at Guy's, and not a position by itself.

At the same time we regret to record the resignation of Mr. Laidlaw Purves, who has so long and so successfully held the post, and whose resignation severs a link with much older generations.

The Coronation is approaching, and the arrangements for this long-anticipated and popular pageant are all but completed. There is little that interests us in particular; but there s one evidence of fanaticism which is deplorable.

We refer to the determination to make the King's Coronation Dinner a cold teetotal function. To those who have been responsible for this cruel and unworthy piece of selfishness we can only say that it is not the way that any reasonable man would treat his guests, were they able to resent it, and that the refusal of a pint of beer, an ample provision, at the actual feast, will probably be a direct cause of intemperance later on.

It is always the aim of the editors to print what is acceptable to the bulk of the readers. The difficulty that is experienced is to know what is acceptable. Like the attendances at board meetings, an absence of grumbling letters means no complaints, for usually, any deflection for duty is instantly, firmly, but pointedly, demonstrated. So that we should be glad to receive any letters or opinions or defects in the selection of articles, and also some information as to the interest of articles generally to the less recent practitioners. From our own point of view, there is no column that is not held up as either the ruin or the salvation of the number by some dogmatic critic.

The South African Memorial Fund is nearly two hundred pounds, and it is proposed to make that sum the basis of the calculation. The meeting will shortly be held, and we can only urge subscribers to send us their views and subscriptions before the decision is taken, that the result may be satisfactory to all.

It is rumoured that changes are in the air anent the College, and although this is an entirely parochial matter it is also of importance. Catering, ever since cooks have existed, has always been a subject of deep interest to all, and of absorbing interest to many, and the general opinion is that, like the "poor in the lump," they are bad. It is to be hoped no hasty decision will be taken without weighing all the possibilities, as frequent changes are as expensive as they are unsatisfactory.

The notices of the Athletic Meeting at Honor Oak Park on Wednesday, June 18th, brings very forcibly before us the fact that spring time (if not spring weather) is here, and we hope the popularity of the meeting, with the attractive "scurry" on donkeys, may still increase; but most of all do we desire that the prizes, which Mrs. Fawcett has so kindly consented to give away, will be the reward of sterling performances, keen races, and good times, because the lack of interest in the Athletic Shield is becoming quite traditional.

The Cricket XI. are to be congratulated on the most striking victory of recent years, even including their overwhelming victory in the Final last year. To defeat our old and formidable rivals at Beckenham in so summary and complete a fashion is as good a start as one could well wish for. It is to be hoped that the season results will not belie the start, but the uncertainty of cricket is proverbial.

The humorous letter on the condition of the Fives Court which was read with great amusement by most people, has produced a promise of repair, but we are somewhat alarmed to find that repair is rumoured to include alteration. The proposal to slope the court surface away from the service wall to allow the water to drain away quickly is specious, but unsound, as it is obvious that the back half of the court will be the last to dry, as the water will be continually passing over it. A smooth wall, floor, and a "squeegee" are the only requisites to render the court as enjoyable as need be. The door we are attached to as it affords a buttress and some incident, but we should be glad to see some more netting round the west side.

Duels Ancient and Modern.

Tempora mutantur, nos et mutamur in illis.

THE noble art of duelling, as generally understood, has fallen on evil days. What was the means of settling points of honour among our grandfathers and more distant ancestors can now find favour only with such excitable creatures as Continental students for the adjustment of their differences—real or imaginary. *Kensington Gardens* and *Wimbledon Common* are given over to more innocent pursuits, and there no more is heard the pistol shot in the chilly grey of morn.

Whether this should be a matter for congratulation has been disputed. Certain it is that the duel has been put to frivolous and vexatious uses, as instance the case recorded by, we believe, the author of "Tom Jones," of an unfortunate being who, in ignorance of the presence of his subsequent challenger and the latter's enamoured, put a wall to the same use as does a London driver a certain part of his chariot under press of circumstances.

But for more serious transgressions there are those who support the duel as being manly and a satisfactory way of venting one's feelings of resentment and indignation consequent on provocation; those there are who consider the end does not justify the means, while the extreme anti-duellists denounce it as a method of barbarism, to use the expression now in vogue.

The champions of the bloody combat argue in this wise. If their sister be insulted—their assumption is limited to their parent's daughter; why? we know not—a remedy is wanting. The insult may be one not recognisable by the law. A visit to the saddler's and a public horsewhipping are low and not worthy the part of a gentleman. The "cons." say that vice never goes unpunished, and whether a sister-insulter or other malefactor, according to the natural order of things, retribution in some shape or form will be meted out sooner or later—a nice, comfortable argument for those whose duellistic attainments might not prevent their coming off second best in a contest if occasion arose.

The cudgels are not always taken up in the above sense vicariously. More often than not he who cries revenge is the one directly aggrieved.

> "Who steals my purse steals trash;
> But he that filches from me my good name,
> Robs me of that which enriches him not,
> And makes me poor indeed."

Ah! the law of defamation and the duels thereunder. Undoubtedly, but for the actions of libel and slander, blood-shedding—high, low, commercial, editorial, and a hundred other varieties—would be a national acccomplishment.

What would become of our slanderers and persecutors, and us the victims of their scourge, to say nothing of the modern school of financial critics, were it not for an omniscient legislature and the much abused jury system? Turning the left cheek to the smiter as a general practice is as obsolete now as ever it was, and in lieu of the duel strictly so-called, otherwise the duel ancient, the action at law, which we will speak of as the duel modern, is a conclusive evidence of the truth of this assertion.

Taken from the standpoint of many people, the duel modern for the vindication of one's honour has advantages which cannot be claimed on behalf of the duel ancient. To begin with, the fighting is, to a certain extent, substitutional. The necessary evil, as the solicitor has most irreverently been called, prepares the weapon for use by the fashionable leader and his helpmate, the blushing junior, who are consulted as to its efficiency before the tournament is declared begun.

Then, when all is in readiness, and enough has been paid on account to satisfy solicitorial necessities, comes the fight. It is not upon a hill top and at break of day. *Publicity is to it as chastity to the virgin, inseparable.*

Generally, the proceedings are conducted in a fine building—though at times somewhat close—in that most favourite of thoroughfares, the Strand, between the convenient hours of 11 and 4, with an allowance of half an hour for lunch.

This is a decided improvement upon the old style of exposure to the elements at cock-crow.

The victim, the bloom of whose character has been despoiled by the infamy of his adversary, commences the attack. This is undertaken by the K.C. mentioned above, who, if he has not a handle to his name, should, at least, be an M.P. The attack is parried as the conflict proceeds by the other side, with the help of cross-examination by a gentleman whose legal and social status should be equal to his friend's. The attack is answered as distinguished from parried by a fresh one, which is parried, as before.

This is the most usual form of combat. At times, the *answer to the attack is more in the nature of a defence.*

If any difficulty should be experienced in grasping the character of the duel modern, as above described, reference should be made to a newspaper report of one, or better still, a visit paid to the *place de combat* when the thing is in progress.

The result of the contest is proclaimed by gentlemen who have what is known as "a property qualification," who, if honour be vindicated, award such monetary solatium as in their judgment is meet.

Prosaic it is; romantic it is not; yet it has this to be said in its favour. No blood is spilt; there is no "woe, unutterable woe," consequent upon "spilling life's sacred stream," as the poet hath it.

There may be woe on one side, or even both, but it results from the payment of damages and bills of costs, in which the necessary evil is not allowed to go unrewarded, nor are the bewigged gentlemen sent empty away. So which is better? To pink your opponent or singe his flesh, *and thereby keep alive the glory of the* duel ancient, or invoke justice, and pray heaven to provide you good counsel, a good judge, a good jury, and last, but not least, good luck.

Each has advantages and disadvantages.

The duel ancient entails maiming or killing, unless conducted on the most approved Continental lines, for the satisfaction of honour at a minimum of risk to the body. Such a course is a poor compromise, and un-English.

For the duel modern it can be said that it is the better for being legal. There are always the accommodating gentlemen who

Strive mightily, but eat and drink as friends,

ready to champion your cause be you of the just or the unjust, and this is no small convenience to the unskilled swordsman or shot who cares not for sorts, sizes, or descriptions, but slings his mud at those around him relying upon the hope that he may coax a jury into a belief in his sincerity and just motives. He can parry the verbal cuts; he knows how to expect them. Oh, thou guileful old wretch! Were the clock set back a hundred years and thou forced to make a choice, how wouldst fare? How wouldst use thy gall with a length of cold steel thro' thy carcass? But the clock is not set back and Grub Street is free to disseminate its calumnies and keep a whole skin if prepared to foot the bill on being vanquished in a duel modern with its victim

Another matter then has to be considered, that of expense, and yet another, delay.

Expense to any large amount did not enter into the duel ancient. The doing and suffering were purely personal, and what honorarium, if any, offered to the seconds was at the prompting of the donor's sense of generosity. Expense of surgical treatment after close of play would probably be borne by a friend. Fleeing the country where death ensued would perhaps entail more inconvenience than pecuniary loss. The hat might be sent round in the event of a sequel at the Old Bailey, and a defence provided by all true lovers of the art.

How different from the duel modern.

Upon the length of one's pocket may depend the issue. Law for both, justice for—but we must not cast aspersions upon our judicial system, for altho' far from perfect, we honestly believe it transcends all others. However, your poor man of mettle who does not set a high value upon his mortal coil, when compelled to fight in accordance with the modern idea, grudges having to disgorge when the fighting goes hard with him. He describes the whole business as a rascally shame, and his ire rises to boiling point when his adversary's bill is presented to him for payment. Beyond the ignominy of the defeat, the rich chicken is unaffected.

As to delay.

That the law is procrastinate is proverbial. Your duel modern is necessarily a long business, altho' that part of it which is fought before the public may but take a few hours. It is the preliminaries that sometimes appear to trench upon eternity; the writs, replies, claims, rejoinders, particulars, interrogatories, and other matters incident to the forensic duel being quite unknown to the duel ancient. To the latter, the services of a friend to carry the challenge, its formal acceptance and a careful selection of your weapon could be made to occupy as short a time as desired.

So we have come to a conclusion of our subject after having discussed it very briefly, pointing out some of the respective merits and demerits of duels ancient and modern.

We have no desire to be held responsible as accessories before the fact to a gory scrap-up as an outcome of a perusal of this article, so be it understood that the subject is discussed from purely an academic point of view and the duel modern must continue in the place of the one ancient till the latter receive legislative approval.

REGINALD CLEGG ATKINSON.

Prizes.

Junior Proficiency Prizes.—Wood, F. T. H., First Prize, £20. O'Brien, A. B., Robinson, M. de L., Lennox-Jones, F. H., Equal, £8 6s. 8d. each. Jones, A. G., 1st Certificate; Allen, R. W., 2nd Certificate; Watney, H. A., 3rd Certificate.

Golding-Bird Gold Medal and Scholarship in Sanitary Science.—Nicol, B. A., Medal and Scholarship. O'Meara, E. J., Special Certificate.

Wooldridge Memorial Prize in Physiology.—Allen, R. W., Robinson, M. de L., Wood, F. T. H., Prize equally divided. Welchman, W., 1st Certificate; Watney, H. A., 2nd Certificate.

Michael Harris Prize in Anatomy.—O'Brien, A. B., Prize, £10. Jones, A. G., Certificate.

To the Sex.

(A Gentle Warning.)

"A sigh is an effort of Nature to correct by an extra deep inspiration the increased venosity of the blood due to inactivity produced by ennui or grief."—*Halliburton's Physiology.*

Maidens, if a man should sigh
As he gazes in your eyes,
Do not ask the reason why
In a tone of sweet surprise.

Think not 'tis some tender chord
You have touched within the youth.
No; he's really rather bored,
That's the—scientific—truth.

Grief may be the cause, I own,
P'raps a sadness o'er him steals,
Thinking of the time that's flown,
Wasted—playing "pills" at Peel's!

But be sure he's not in love,
For the scientific man
Sighs for reasons seen above.
Doubtless you can make them scan.

In Lighter Vein.

The Conversazione in the new Nursing Home was a magnificent function, and was attended by all the celebrities of this celebrated Hospital. The christening was performed by the President of the Residents, who, after enquiring where everybody was, threw a bottle of Bass at the front door and named the Home "The Cosmo Asylum for Overwrought Nurses." He was loudly cheered by the ward-maids

The Guests were received by Dr. Perry (in academic robes) and the Matron, who sat on the bottom step of the grand staircase. Mr. Cosmo Bonsor acted as chief usher with Victor as his aide-de-camp.

A variety entertainment was held in the large dining-hall and there were numerous and interesting side shows.

In the large room on the left there was a collection of antiquities. Here Dr. Pye-Smith showed several different kinds of stethoscopes and illustrated their application; he said they were just as useful to a deaf man as they were to anyone else.

Dr. Bryant showed the electrical apparatus at present in use in the Hospital in full working order, without any connection with the Hospital electricity or indeed any other; he reassured the visitors by telling them that it was as harmless as it was useless.

Mr. French (who was in charge of the cloak room) exhibited an amusing collection of hats that had been worn by the Staff of the Hospital, he explained how unfortunately the collection could not be made permanent as many of the objects were still in everyday use.

Mr. Coles was going to show the Hospital instruments, but they were unfortunately all required for an urgent operation in the theatre.

Mr. Howse showed a carbolic spray and some green protective.

Mr. Betts showed himself.

In the swimming there was a great attraction in the shape of a fishing competition between Mr. Higgins and Mr. Brailey with strabismus hooks; the former (who offered 5 to 1 on himself) used the *Sporting Times* as bait; whilst the latter hung on his hook a tract kindly supplied by Sister Ruth. The competition ended in a draw. Dr. Savage umpired and took a professional interest in the performance.

In another room were six solemn young men, each looking down a microscope, they offered to blood-count every one that went in. They told us the secret of their great success in life—blood-counts; the reason they never took in an alcoholic coma by mistake—blood-counts; the reason they took in small-pox—blood-counts; the reason they were what they were—blood-counts. I heard one of them call another a megaloblast, and being with a lady I blushed deeply and hurriedly left the room.

A hot contest took place in the ping-pong room between Dr. Horrocks and Dr. Pitt. The former declared that he would have won if he hadn't injured his knee; Dr. Pitt, with the flush of victory on his face, sympathetically examined the inflamed joint, and ordered mist. colchici cathart.

The refreshment room was deserted, except for a kitchen-maid, who was trying to kill a red herring.

Space does not allow me to describe fully the performance in dining-hall, but the official programme is printed below. The proceedings were opened by Mr. Lucas, who, supported by his H.S. and the Leucocytes (differentially stained by the clinicals), insisted on making a speech. He said, "My lords, ladies and gentlemen, as Senior Surgeon to this great and glorious institution, of which we are all so justly proud—— so justly proud—— I say, so justly proud——" The rest of the speech was drowned by general conversation, which only ceased when Dr. Galabin stepped on the platform, and began his conjuring tricks. His assistant, Mr. Lewin, held a black bag, out of which the operator produced a book on Mechanics, "Chambers' Tables of Logarithms," "The Differential Calculus," tents, toys and instruments. The public interest was here distracted by the hurried entry of a large black cat, followed breathlessly by Messrs. Curtis and Ticehurst. Mr. Curtis in his hurry, unfortunately, upset Mr. Jacobson, who said "brutes," and apologised for being in the way. Dr. Shaw

gave a determined blink, and with great presence of mind threw his umbrella at the cat. Much to the surprise of everyone, he for once made a bad shot, and the umbrella struck Mr. Lane heavily in the region of the spleen. Mr. Lane remarked that we were having a lot of weather, and said Dr. Shaw looked well. The cat was rescued by Nurse Stevens, who put it in her pocket, where it ate her tame sparrow —— Then I awoke, and behold, it was a dream.

OFFICIAL PROGRAMME.

Stump Speech - - - - - - Mr. Lucas.
Loud Applause - - - - - - His Dressers.
Sleight of Hand - - - - - - Dr. Galabin.
Song, "The Honeysuckle & the Bee" Mr. John Atkins.
Recitation, "I am monarch of all I survey" Dr. Perry.
Basoon Solo - - - - - - Mr. Chas. Robson.
Essay, "With the Boys in South Africa" Mr. Fripp.
Expert Criticisms: Bullets Shown - Mr. Lucas.
Recitation, "She's little but she's wise" The Matron.
"Dead March in Saul" - - - The Clinicals.
"When we were Girls," Early English Song
The Sisters.
Lecture, "The Diagnosis of Drink" - Mr. Prestige.
Expert Criticisms - - Messrs. Odgers & Gray.
Song, "Away in the West when the Sun went down"
Mr. Dunn.
Song, "I dream't that I dwelt in Marble Halls"
Sister of New Home.
Part Song, "Our Lodger" - - Mr. and Mrs. Fagge and Mr. Ormond.
"God save Dolly Gray" The Choral Society.
Led by Mr. Cosmo Bonsor.

ALI BABA.

Pass List.

University of Durham, April, 1902.

Examination for the Degree of Doctor in Medicine
(For Practitioners of Fifteen Years' standing).
G. F. Pollard.

Bachelor in Medicine and in Surgery.
M. C. Wetherell.

Examination for the Diploma in Public Health.
A. Reid.

Royal College of Surgeons of England, May, 1902.

Primary Fellowship Examination.—F. Barnes, J. H. Clatworthy, R. Felton, H. T. Hicks, E. C. Hughes, W. M. Mollison.

Final Examination for the License in Dental Surgery. May, 1902.

Parts I. and II.—H. T. Binns, J. Cameron, H. J. Coish, H. S. Cranston, E. F. Deck, J. A. Donald, E. E. Lacey, W. C. Lyne, L. Myer, W. Reynolds, P. Scott, J. S. Shoveller, H. Thacker.

Part I. only.—H. Bacon, *O. Black, *T. A. Chignell, *W. Giles, *A. E. Steele Perkins, *W. K. Perry, J. F. Rey, A. B. W. Rust, *A. E. Stroud, H. W. Wallis.

Part II. only.—T. C. Holford, *W. H. Solomon, *J. W. Walton.

*Denotes completion of examination.

FIRST PROFESSIONAL EXAMINATION FOR THE LICENCE IN DENTAL SURGERY.

Mechanical Dentistry and Dental Metallurgy.—L. H. Barlow, F. W. Bartle, F. Chilton, H. E. Collett, W. C. M. Dickey, G. L. Dymott, R. B. Glendining, W. J. Goodman, H. P. Hooper, C. J. S. Kliszczewski, H. C. Malleson, B. H. Martin, R. J. Messent, J. A. Oates, C. L. Palmer, F. W. Parfitt, G. R. Phillips, S. A. Piper, E. N. Plummer, A. E. Preston, C. W. Randall, R. Roberts, G. G. Timpson, C. L. D. Taylor, H. E. H. Tracy, A. O. Trotter, C. D. Wallis, W. H. Yeo.

Dental Mechanics only.—A. R. Beaumont, W. E. Derriman, T. J. Green, N. James, A. E. Williams.

Dental Metallurgy only.—F. J. Cutler, F. N. Palmer, R. A. Scott.

From the Gazette's Special Pathologist.

All specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. Wells.

NOTICE.

T. H. D. H., Reigate.—This sputum consisted chiefly of mucus entangling a little pus, but in suitably stained portions the tubercle bacillus could not be found.

PATHOLOGIST.

Reviews.

The price of books submitted for review should in every case be stated.

Clinical Methods. (Hutchinson & Rainy). A new and revised edition has been issued. It is needless to notice it at length as it has for some time been recognised as essential to all Medical Ward Clerks, and also as a reference book for more advanced students.

We have received a book entitled *Mentioned in Despatches (Army & Navy Gazette*, 3, York Street, Covent Garden, W.C., 1s. 2d. post free), which gives the whole of the mentions, honours, and special promotions in the Navy and Army in connection with the South African Campaign, which have been gazetted up to May 6th.

We extract from the volume a summary of the honours bestowed upon the medical branch. The share of the Navy is very small, being only two D.S.O's. The Nursing Sisters and other ladies have had forty-eight Royal Red Crosses. To the Army, and we include those consulting and civil surgeons who volunteered for service and also Colonials, there have been awarded five V.C.'s, one K.C.B., twenty C.B.'s, two K.C.M.G.'s, forty-seven C.M.G.'s, and thirty-seven D.S.O.'s. Non-commissioned officers and men have thirty-eight Distinguished Conduct Medals, and a Sergeant-Major has been awarded a bar for the medal he already possessed. The book contains nothing new—all the information has been given in the pages of the *London Gazette* during the last two and a half years—but everything is presented in a concise form convenient for reference, and we are sure it will be welcomed by all who have friends or relatives mentioned or promoted for their gallantry and devotion to duty.

From Cradle to School. By Ada S. Ballin. (Published by Archibald Constable & Co.) Price 3s. 6d.

"*From Cradle to School*" is an excellent book for the upbringing of children, and most useful to young mothers and those who have the care of young children. If the rules and treatment of young babies and children were carried out on these lines, there would be fewer deaths, and much pain saved to the little ones. The chapters on food, clothing and education are splendidly worked out; but Mrs. Ballin seems rather afraid of fresh air, both in sickness and health, and the fear of friends kissing children is somewhat faddy, and would often cause offence, also the chapter on "How to make children pretty" would make them self-conscious and vain. Excellent as the book is in many ways, and numberless the useful hints it contains, it would need much money to follow out in detail all the rules laid down, and the mother of the working classes need as much help in the bringing up of their children, as the mothers of the higher classes.

South African Memorial Fund.

WE are pleased to be able to announce that the sum now subscribed for the Memorial to Guy's men who have fallen in South Africa has reached £200; but it is hoped that further donations may yet be received before the Fund is closed at the end of the present month.

TENTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	182	8	0
J. F. Goodhart, M.D.	5	5	0
G. T. Willan	2	2	0
K. B. Alexander	1	1	0
H. Cooper, M.D.	1	1	0
Montagu F. Hopson	1	1	0
A. Shillitoe, M.B.	1	1	0
G. T. Willan, Junior	1	1	0
Reginald Willan	1	1	0
Richard Willan	1	1	0
H. W. Bruce, M.D.	1	0	0
A. H. Carter, M.D.	0	10	6
George Eastes, F.R.C.S.	0	10	6
T. L. Jackson, M.B.	0	10	6
W. T. Milton, M.S.	0	10	6
T. D. Paradise	0	10	6
R. Tilbury	0	10	6
W. E. Robinson	0	10	0
J. S. Richards	0	5	0
R. M. Barron	0	2	6
H. C. Keates	0	2	6
W. M. Robson	0	2	6
P. G. Temple	0	2	6
	£202	10	0

Papers by Guy's Men.

An Analysis of forty-six cases of Cancer of the Breast which have been operated upon and survived the operation from 5 to 32 years, with remarks upon the Treatment of Recurrent Growths, including the Disease of the Second Breast, operative and otherwise. By Thomas Bryant, M.Ch., F.R.C.S.—*British Medical Journal*, 17th May.

The Quiescent or Latent Period in the Course of Grave Abdominal Inflammation. By A. H. Tubby, M.S., F.R.C.S.—*Lancet*, 10th May.

A Clinical Lecture on Septic Polyarthritis. By G. A. Wright, B.A., M.B., F.R.C.S.—*Lancet*, 17th May.

The Treatment of Malignant Stricture of the Œsophagus. By F. J. Steward, M.S., F.R.C.S.—*The Clinical Journal*, 21st May.

The Nurses in Fiction.

We have been wakened from a peaceful dream, another of our ideals is broken, another fond delusion gone. We had imagined that, though the medical student was all that is bad and brutal, the nurse was a bright and shining example of what a woman could do to make the world a more comfortable place. But alas, we may no longer think this. Miss M. E. Johnson writes in the *Nineteenth Century* on the nurse as she is, and our ideal nurse is gone, and in her place—well, we would rather not meet the lady that Miss M. E. Johnson gives us in her place. There is a little tale told at the beginning of the article of a criticism by Ruskin of a famous picture. Ruskin can only find one point in the picture which he does not criticize. But Miss M. E. Johnson goes one further. She has out-Ruskined Ruskin. She can leave no point uncriticized; the nurse has no virtues. True, she has saved lives. Yes, and affected marvellous cures; but we are led to understand that she has rendered these saved lives so miserable that the poor victims have begged to be allowed to die in peace unnursed. And small wonder, for the nurse is a terror. She rides on the top of omnibuses; she talks "shop" to her friends; she corrupts happy homes with tales of hospital scandals, and when she goes to nurse a patient in a private house the whole family break down under the burden of tending and waiting upon the nurse. It is indeed a terrible picture, and we admire the courage of Miss Johnson in exposing herself to the wrath of these harpies by publishing their evil deeds. We are cast into the depth of despair as we think of the day when we as G.P.'s shall have to commit our treasured patients to the tender mercy of the nurse. But then there comes a ray of light, Miss Johnson having pointed out the black depths to us is ready to help us out. She knows where the fault lies; she knows how it can be remedied, and where is the fault? Why, at our very doors—in the great hospitals. Day by day girls from all classes of society—good gentle girls—are entering the hospitals as probationers, and day by day these terrible women, these trained nurses, are being sent out to add to the world's load of misery. The three years' training does it, transforming the gentle girl into the hard unsympathetic wretch.

It is difficult to see how such things can be. Most writers would find it almost impossible to convince us that the hospital training could have such dire results, but Miss Johnson carries all before her with her masterly logic and her brilliant imagination. Step by step our reason is convinced, and we see before us painted in life-like colours the picture of life in the hospital. The unlucky "Pro" bullied and "nagged" from morning to evening by the sharp-tongued sisters and nurses; the wild rush of work with never a minute to read the *Daily Mail*; the short time off duty, just enough for a little shopping. (No days off.)—it all glows before us. We realize the horror of the whole thing and we resolve to close the hospital till such time as Miss Johnson can come and show us how nurses should be trained.

Perhaps this article has been treated with more consideration than it deserves; but when a review, the contents of which are usually supposed to be worthy of the attention of the thoughtful public, publish such statements as are made in this article, it is time to think why the nurse in fiction is such an utterly different person from the nurse as we know her; and one would like to ask a few questions as to the source of Miss Johnson's knowledge of nurses and their ways. Does she for one moment imagine that all the women she meets in nurses' garb, calling themselves nurses, have any right to the title? Is it not possible that many of them have not seen the inside of a hospital, or only for a short time, and that their faults may not be the result of hospital training, but rather result from the lack of it? We all know of the women who have been failures in the hospital—who were obviously not fitted for the work of a nurse, and who have gone to private nursing institutions, where they are let loose on the public as "trained hospital nurses." But they are not. No hospital owns them. They can show no certificate. It is from these women that the public gets its idea of the nurse, and so long as these "nurses" are allowed to flourish in the land shall we have these attacks, and hear of the truly wonderful nurse of modern fiction. When the public realises this, and demands the real hospital nurse, who has her three years' certificate, and can point to a satisfactory hospital career, and do away with the private nursing homes, run by women trained or untrained, who mind not at all what kind of woman they get on their staff so long as they will work for the meagre wage given.

When there is a Register of Trained Nurses—and no woman shall have a right to call herself a nurse unless her name is to be found there—then the public will be able to criticize the Nurse, and decide what her faults are. Then perhaps we may have a nurse in fiction that we can recognise. Now the public don't know when they have got the Nurse or only the sham.

There is another side to the question. There is a great deal said about the way the nurse treats the household she is sent to tend and comfort, but is there nothing to be said of the way the said household sometimes treats her? When she expected to be so much the ministering Angel as to require neither sleep or food, is it to be wondered at if sometimes the Nurse, not being an Angel, but only a woman, arrives at an unknown house determined to "have her rights" in the matter of sleep and food, and to have some want of tact in her demand for them. Had Miss Johnson known anything of the working of a hospital ward? She may have heard much, read much, but has she ever spent a day or even an hour in a ward as a patient or the friend of a patient? If so she would hardly, she *could* not say that it is *there* that the Nurses learn to be bad, selfish or unsympathetic.

Sport.

Cricket.

The Freshmen's Trial Match took place on Friday, May 9th, between eleven chosen by H. D. Wyatt and F. Morres. The scoring was not high, the chief contributors being Allison, Davies, Fox and Matthews. Considering the state of the wicket Davies, Russell and Munro bowled well. We have lost Graham Smith, perhaps the best wicket keeper the Hospital ever had, and a capable successor is still to seek. One may hope that some enthusiast will by constant practice endeavour to qualify himself for this all important position.

Our bowling lacks variety and we hope that the sudden awakening in some quarters of a touching, if belated, enthusiasm for examination work will not prevent us playing a full team regularly.

GUY'S v. BECKENHAM.

Played at Beckenham, on Saturday, May 10th. This victory, coming at the beginning of the season, was most gratifying. Beckenham had a very powerful batting side, and the small total of 185 they compiled was largely due to our XI. displaying the requisites of a good fielding team, readiness of resource and dash. Barber played a very fine innings of 80, in which he showed capital defence and hitting powers, and with Wyatt, added 152 for the first wicket. Langdale, who made 58 not out, hit brilliantly, and Morres batted well for 43. Wyatt took eight wickets for 69 runs. Teams:—

BECKENHAM.

F. D. Browne, c Langdale, b Wyatt	29
H. Z. Baker, b Wyatt	12
P. Collins, c and b Wyatt	5
A. Brown, b Morgan	16
P. C. Baker, c and b Wyatt	1
A. A. Tonens, c Foster, b Wyatt	0
H. E. G. Boyle, c Louisson, b Wyatt	11
G. J. Gulliver, b Foster	22
O. A. Bishop, not out	0
A. A. Baker, c Morgan, b Wyatt	43
R. Bowell Williams, c Barber, b Wyatt	36
Extras	10
Total	185

GUY'S.

H. Barber, c Tonens, b Collins	80
W. D. Wyatt, c P. C. Baker, b Boyle	64
H. M. Langdale, not out	58
F. Morres, c A. Baker, b Williams	43
E. L. Norton, not out	8
Extras	14
Total for 3 wickets	267

S. C. Bowle, H. A. Tolhurst, E. Morgan, A. L. Foster, J. Bookless, and M. G. Louisson did not bat.

GUY'S v. BLUE MANTLES.

This match was played at Tunbridge Wells o Wednesday, May 14th, on a hardening wicket in fine but chilly weather, and ended in a draw. For Guy's Barber played a useful innings; his defence is as safe and his playing as neat as ever, and he was admirably supported by Langdale and Bowle. Our bowling was poor and our fielding moderate. For Blue Mantles Rendle played an excellent innings. Teams:—

GUY'S.

H. Barber, c Barrow, b Kelsey	102
H. D. Wyatt, c. Munro, b Wilson	9
H. M. Langdale, c Havers, b Wilson	51
F. Morres, b Kelsey	6
E. L. Norton, st Barrow, b Kelsey	10
S. C. Bowle, c & b Havers	35
E. A. Collins, st Barrow, b Kelsey	9
G. N. Bartlett, c Stone, b Kelsey	7
J. Bookless, not out	10
A. L. Foster, c Barrow, b Havers	0
M. G. Louisson, c Barrow b Havers	0
Extras	13
Total	250

BLUE MANTLES.

— Rendel, c Collins, b Bookless	81
— Whatley, b Foster	14
— Harvey, c Collins, b Foster	0
F. W. Mitchell, b Wyatt	6
L. D. Barrow, c Bartlett, b Bookless	19
J. E. S. Wilson, not out	9
C. Philcox, not out	2
Extras	12
Total for 5 wickets	143

R. M. C. Munro, A. C. Havers, R. Stone, J. H. Kelsey, did not bat.

GUY'S 2ND XI. v. THESPIDS.

Played at Honor Oak Park, and ending in a win for our opponents by 12 runs. R. Willan (junior) played a good innings for his 75 on our side. Score:—

THESPIDS.

C. Aldred, b Carlisle	12
L. Lockner, b Munro	2
R. Evatt, lbw Willan	64
C. Childerstone, c Munro, b Willan	6
H. Nye Chart, c Carlisle, b Munro	5
Westerton, b Munro	3
Harding-Cox, b Carlisle	16
J. Boddy, b Carlisle	6
T. Terris, b Willan	2
Pye, c Turner, b Willan	6
Webbe, not out	1
Drinkwater, b Willan	0
Extras	32
Total	155

GUY'S 2ND XI.

S. C. Bowle, b Childerstone	1
F. Morres, b Lockner	15
R. Willan, Jun., b Childerstone	75
J. Munro, lbw Lockner	4
A. H. Turner, b Evett	0
W. H. Bush, b Westerton	10
L. Gibson, run out	0
G. Carlisle, b Childerstone	0
G. Russell, c Nye-Chart, b Childerstone	4
Bennett, run out	7
Harding-Cox, c Lockner, b Childerstone	3
Blakeley, not out	5
Extras	19
Total	143

Appointments.

NAVAL AND MILITARY.

STAFF-SURGEON W. J. MAILLARD, M.D., V.C., R.N., has been placed on the retired list. He was appointed Surgeon, August, 1889, and Staff-Surgeon, June, 1899. Dr. Maillard was awarded the Victoria Cross for his conspicuous bravery during the outbreak at Candia on September 6th, 1898, as recorded: "During the landing of seamen from H.M.S. *Hazard*, Surgeon Maillard, who had disembarked and reached a place of safety, returned through a perfect deluge of bullets to the boat, and endeavoured to bring into safety Arthur Stroud, ordinary seaman, who had fallen back wounded into the boat as the other men jumped ashore. Surgeon Maillard failed to bring Stroud in only through the boat being adrift, and it being beyond his strength to lift the man (who was almost dead) out of so unstable a platform. Surgeon Maillard returned to his post with his clothes riddled with bullets, though he himself was unhurt." He was specially promoted to Staff-Surgeon, June 2nd, 1899, for distinguished service. We regret to learn that the cause of the retirement of Staff-Surgeon Maillard is serious ill-health. All will regret that a career of so much promise should have been brought to a premature termination.—*British Medical Journal.*

SURGEON ARTHUR R. THOMAS, R.N., is appointed to the *Hearty*.

COLONEL W. E. SAUNDERS, C.B., is appointed Principal Medical Officer, Poona District.

The resignation of SURGEON-LIEUTENANT H. W. WEBBER, M.D., 2nd Devonshire Volunteer Garrison Artillery, which was announced in the *London Gazette* of April 22nd, is cancelled.

Solution to Case for Diagnosis.

On the evening of the fifth day a miscarriage occurred, the child, æt. six months, was born alive, and a large, old blood-cast of the fundus was expelled as well. The pulse, which had slowly been falling remained at 80–90; afterwards she did well. Afterwards the distension and the tenderness remained, but the constipation was relieved.

It is quite clear that the cause of her seeking admission was a concealed accidental hæmorrhage, though it is very likely that she has some other pathological lesions present such as old tuberculous adhesions or possibly some fæcal ulceration along the bowel as the result of constipation.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Birth.

PEMBREY.—On May 5th, at Parkside, Clewer Green, Windsor, the wife of M. S. Pembrey, M.D. Oxford, of a son.

ED.—D. G. G.

Contents.

	PAGE
SOME CONVULSIVE DISORDERS: Clinic l Lecture by Dr. Taylor	229–237
CASE FOR DIAGNOSIS	237–238
OBITUARY; Edwin Stott	238
PASS LIST	238
PAPERS BY GUY'S MEN	238
PASSIM	239–240
TWO DOCTORS	240–242
NOVELTIES	242
THE "NINETEENTH CENTURY" NURSE	242–244
CORRESPONDENCE: South African Memorial Fund; South African Civil Surgeons' Dinner	245
SOUTH AFRICAN MEMORIAL FUND: Eleventh Subscription List	245
SPORT: Cricket—Guy's v. Blu Mantles; Guy's v. Surbiton; Guy's 2nd XI. v. Hos.-Scho.; Guy's 3rd XI. v. Enfi ld Lock: Guy's 3r XI. v. Christchurch "A"; Guy's 3 d XI. v. Camberwel House Asylum. Lawn Tennis—Guy's v. Gravesend; Guy's v. Wanste d	246–248
APPOINTMENTS	248
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	248

Calendar of Coming Events.

June, 1902.

Sat. 7.—Messrs. Golding-Bird and Dunn's take-in; Drs., J. Bromley and R. Willan; Cl., F. L. Thomas.
G.H.C.C., I., v. R.I.E.C. Cooper's Hill, away.
II., v. St. Bart's "A," home.
III., v. New Eltham, away.
G.H.L.T.C., v. Blackheath "A," away.

Mon. 9.—1.15 p.m., Clinical lecture by Dr. Horrocks.
July Appointment List closed.
Last day for applying to Registrar for form of entry for Inter. M.B. Lond. Exam.
Cambridge 1st and 2nd M.B. Exams. begin.

Tues. 10.—12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 11.—1.30 p.m., Clinical lecture by Dr. Hale White.
G.H.C.C., I., v. Hampstead, away.
II., v. City of London School, home.

Thur. 12.—Messrs. Jacobson and Fripp's take-in; Drs., H. Watts and H. D. Smart; Cl., G. T. Wrench.
Application to Medical School Office for Schedules for the Second Conjoint Exam. to be made not later than this date.

Fri. 13.—9 a.m., Special Exam. for Dental Operative Prize.
1.30 p.m., Clinical lecture by Mr. Fripp.

Sat. 14.—G.H.C.C., I., v. Eastbourne, away.
II., v. Old Charlton 2nd, away.
III., v. Addiscombe "B," home.
G.H.L.T.C., v. Wanstead, home.

Mon. 16.—1.15 p.m., Clinical lecture by Mr. Brailey.

Tues. 17.—12 noon, Mr. Rowell's Demonstration on Anæsthetics.
G.H.C.C., I., v. M.C.C., home

Wed. 18.—1.30 p.m., Clinical lecture by Dr. Hale White.
G.H.C.C., II., v. Merchant Taylors' School, home.

Thur. 19.—Messrs. Symonds and Steward's take-in; Drs., H. C. Winckworth and J. S. Cooper; Cl., W. H. Bowen.

Fri. 20.—1.30 p.m., Clinical lecture by Mr. Fripp.

Sat. 21.—G.H.C.C., I., v. Past, home.
II., v. Alleyn, away.
III., v. Old Golfeians, away.
G.H.L.T.C., Past v. Present, home.

Guy's Hospital Gazette.

JUNE 7, 1902.

Some Convulsive Disorders.

CLINICAL LECTURE BY DR. TAYLOR.

March 15th, 1902.

GENTLEMEN,—I have intimated that I am going to lecture on Some Convulsive Disorders, and I daresay you will realise that the term *convulsion* is almost as difficult to define as some other terms in medicine, such as *life*, or *disease*, or *coma*, or *delirium*. I have attempted a definition of convulsion, which is, that it is a morbid involuntary contraction of muscle. I have seen a recent definition of convulsion—that it is an excessive discharge of nerve energy. It seems to me that though that represents one phase of some forms of convulsion, it does not cover the whole ground. Indeed, a convulsion is, in itself, scarcely a discharge of nerve energy; it is the result of the discharge of nerve energy. Surely Sandow's efforts are excessive discharges of nerve energy, but perhaps it is scarcely fair to call the resulting movements convulsions in the sense in which we commonly use the term in medicine. Clearly one important feature of convulsions, as we use the term, is their involuntary character, and another is their unnatural occurrence, that is their uselessness for the economy of the body. In other words, they are morbid.

Vierordt, a German writer, says that if one comprehends under the title convulsions all movements which are morbid and beyond the influence of the will, we must go a deal beyond popular conception of convulsions; but that this cannot be avoided if we do not wish to dissociate the elements of the subject from one another.

I have here a list of the different kinds of morbid muscular contractions.

TONIC CONVULSIONS.

Trismus.
Tetanus.
Opisthotonus and spasm in meningitis.
Spastic conditions in spinal and cerebral lesions.
Tetany.
Myotonia congenita.
Writers' cramp.
Hysteria.
Catalepsy.

TREMORS.

Senile.
Alcoholic.
Saturnine.
Graves' disease.
Nervousness.
Muscular exhaustion.
Paralysis agitans.
Multiple sclerosis } "intention tremors."
Mercurialism }
Rigors { toxic. / hysterical.
Fibrillary tremors.

CLONIC CONVULSIONS.

Organic cerebral disease { tumours. / meningitis. / injury. / vascular lesions.
Epileptic.
Uræmic.
Alcoholic.
Puerperal.
Infantile.
Hysterical.
Forced movements of cerebellar disease.
Spasmodic wryneck.
Chorea.
Athetosis.
Paramyoclonus multiplex.
Associated movements.

I am not going to illustrate every one of the above movements by cases, but I will call your attention to the attempted classification that I have made. You will see that some are described as tremors; others are called clonic convulsions, that is, convulsions in which the muscular movements alternate with contraction and relaxation; and others again are called tonic convulsions, in which the condition is one of more or less persistent contraction of muscle without relaxation.

Then one has got to ask the question how the word *spasm* is to be used, and whether spasms are different from convulsions. Certainly the terms are used with a somewhat different limitation or extension, and one is more apt, on the whole, to think of the clonic convulsions as typical convulsions, and tonic convulsions as spasms. Still one speaks sometimes of clonic spasms and of tonic convulsions, and therefore conditions of spasm and convulsion cannot be readily separated from one another.

Although one recognises that the term tremor is more especially confined to conditions in which you have minute inextensive movements occurring comparatively rapidly and covering a small area of space, and thus one may think of them as very different from the more violent movements which characterise some convulsions in epileptics and others, still it is very difficult to draw a definite hard and fast line between them. If in tremors there is alternate contraction and relaxation of muscle, the condition is practically the same as in clonic convulsions. A rigor is a violent tremor, and it is very near indeed to an obvious convulsion. A fibrillary tremor, a slight contraction of the separate fibrillæ of muscles such as we see in certain diseases, is not very far removed from those movements which are seen in the commencement of epileptic convulsions, when you get twitching in the limbs, of which the patient does not seem to be aware, and which are very inconspicuous.

It is interesting to ask what is the seat of the different forms of convulsions. Convulsions, we have allowed to be the result of discharges of nerve energy, the seat of which, of course, is the nervous system. In most instances, I think, that we have to deal with here, they can be shown to have their origin in the cerebral convolutions, and that is especially true of the clonic form of spasm. As an illustration take the condition known as Jacksonian epilepsy, where the convulsions are the result of discharges of nervous energy limited to the motor convolutions. Frequent instances of this condition arise

in cases of tumour of the cortex of the brain. On the other hand, many more fixed or tonic spasms or convulsions are present in cases where the lesion appears to be somewhat lower down than the cortex, either at the base of the brain or in the neighbourhood of the upper part of the spinal cord, such, for instance, in the tonic contractions characteristic of posterior basal meningitis, in which the head is retracted in the position of opisthotonus, and the spasmodic conditions of spinal meningitis, tetanus, and strychnine poisoning. In these cases you get tonic contractions of muscle, and they are conditions in which the spinal cord is chiefly involved. But you must not take this as an absolute and fixed limitation as to the localisation of these forms of movement. For instance, in the fibrillary contractions to which I was referring, you may undoubtedly have convulsive or twitching movements, though limited to very small areas. These twitchings are seen especially in the condition known as progressive muscular atrophy, where the lesion is a spinal lesion; but they are also seen occasionally in those cases in which, as far as we know, the muscles are primarily affected. And thus one must remain in some doubt as to whether such twitchings arise in the spinal cord or from a trophic lesion in the muscle, independent of any nerve action whatever. But certainly they do not depend in this case on a cerebral lesion. That tonic convulsions may be produced by lesions which are at least primarily cerebral, is shown in the tonic stage of epilepsy, and in catalepsy.

In spite of the great number of different forms of contraction which can be enumerated, you can distinguish the greater number from one another by careful consideration, either of the physical features which they present, or of the associated conditions.

In the study of convulsions you have to consider, (1) the character and variations of the movements themselves, (2) the limbs or part affected, and especially the parts of the body in which the convulsions first of all take place, and (3) the presence or absence of consciousness during the fits. What you seek by these enquiries is to find out exactly where the causative lesion is situate.

You are, of course, familiar with the fact that convulsions which start in one point may spread to different parts of the nervous system, and that a lesion in one part of the brain which is of a nature to produce convulsions, whatever the lesion may be, is called a discharging lesion, which means that it is able to produce discharges of nervous energy; and these result in morbid movements. And discharging lesions certainly may be of very different kinds. For instance, tumours and meningitis and apoplexy are in their turn discharging lesions productive of convulsions, which affect primarily the part of the body which corresponds to the seat of the lesion, but which may, as a matter of experience, result in the production of convulsions over the whole body, the irritation spreading from one part to another in accordance with certain physiological laws, which have been proved both by experiment and disease.

With regard to the movements themselves, whether they be tremors or convulsions, one has to notice whether they are quick or slow, fine or coarse, whether they are purely rhythmical, that is to say, simply consisting of alternate contractions and relaxations of antagonistic muscles; or if they are more irregular; or if they are combined movements, as in chorea, where you see twisting and writhing movements, from a combined action of several groups of muscles, different from the simple to-and-fro movements in some other forms of convulsions. You also see, especially in conditions of hysterical convulsions, and alcoholic convulsions, what I have called purposive movements; movements which seem to be effected with a definite purpose, as a pushing away, or a drawing to, or a striking out. Further, you want to notice whether these movements are uniform in the extent of time occupied in these acts, or whether you have a more rapid contraction with slow relaxation, the characteristic, that is, of the movements which are commonly called jerking or twitching, and which are, perhaps, in accordance with the popular imagination, more often called convulsive.

I will now proceed to deal with one or two of the cases that we have had in Clinical ward. We have there a patient who has had two fits. Another case is a patient who had a cerebral lesion and fits when he was young and who has now a condition of weakness of one arm and leg, with a moderate spastic condition. A third case is that of a man, who suffered an injury to his brain, thirty-seven years ago, and who is now the very unfortunate possessor of an arm which he cannot keep quiet except by strapping it to his side and thereby fixing it continuously day and night.

The first patient is a man, aged 53, who was admitted on the 12th of this month for the loss of power of expressing himself and for fits. "He suffered from sciatica and pleurisy some years ago. Three weeks ago, when he was at the docks, he found suddenly that while he could understand what the men under him were doing he could not direct them in their work. His wife says that he came home the some evening looking ill and complaining of headache, and that since then he has been altered, being languid and feeling tired and worn out. His appetite was poor, he was sick in the morning, and he had pains in his legs. But the temporary aphasia passed off next day and has not returned until the present attack. His wife is quite positive that he has had no fits during the fourteen years she has known him."

The history of his present illness is as follows. "He left home this morning at four o'clock. His wife says he went out perfectly well and spoke to her quite sensibly. At 8.30 a.m. he was steering a barge when he was noticed to fall down suddenly. Two river policemen were called to him and found him unconscious and bleeding slightly from the mouth. He remained in this condition for twenty minutes and, recovering consciousness, was found to have no knowledge of where he was or how he came to be in that condition. Further, he could not speak. When seen at the front surgery at 10 o'clock, he was unable to speak sensibly or connectedly, but continually stopped for a word, and giving up the attempt to find it. At 10.20 he had a fit; it began with a cry, and then a tonic contraction of the right side was noticed. The fit, however, soon became general, and the tonic spasm gave way to clonic convulsions, involving equally both sides of his face, both his arms and both his legs simultaneously. He became cyanosed, and before he could be helped had bitten his tongue. The clonic convulsions lasted just over a minute. After this he remained unconscious for fifteen minutes. He was then removed to the ward."

On admission, his pulse was 80, respirations 20, and temperature 95°. "Patient is a fat, plethoric subject. His face is red, with dilated veins upon it. He has no pain. He is quite conscious, but does not realise where he is. Moreover, he cannot give or write his address. He begins, '26 Fourth' (leaving out 'Trafalgar Place') and then stops. He cannot give the correct name to a *safety-pin*, but calls it a *pen*, although he knows that it is something with which he fastens the flannel which he wears. He calls a *pen* a *paper*, or, if he attempts any continued conversation, gets stopped by the want of a word and, as a rule, says 'Twickenham.' He can read print correctly. He has no loss of sensation or of motor power. His pupils are equal, of normal size, and react both to light and to accommodation equally well. His knee-jerks are equally brisk on either side. He has no ankle clonus. His discs appear to be normal in character. His pulse is not markedly of high tension; it is regular and of good volume. His heart is normal. His lungs are slightly emphysematous; otherwise they are normal. His urine is pale in colour; it is acid; sp. gr. 1012; it shows a trace of albumin, but no sugar. The edge of the liver is a finger's breadth below the costal margin. Otherwise the alimentary system is normal."

You observe that he is a fat, red-faced man, 50 years of age, and looks like a man who has lived on the river and followed a laborious occupation, and probably drunk a good deal of beer—a man in whom, though we do not recognise any high vascular tension, it is quite probable that the vessels are not perfectly sound.

The question we have to consider is, What is the nature of these fits? They appear to have been general convulsions starting at one

point. All that we positively know, so far as these convulsions are concerned, is, that he had one fit, and it is highly probable, of course, that the unconsciousness which he experienced about one and a half hours before coming in, was accompanied by some such convulsions as were seen in the surgery here. It is highly probable that he had two fits separated by the interval of confusion in which he came to the hospital, and during which also he was to a certain extent aphasic. You will notice further that soon after that the aphasia was much less, and the patient now is practically recovered. He has had no more fits.

The general convulsions one has to consider in a case of this kind—that is to say, fits occurring in an adult, and involving the whole body, even though they start at one spot—come under one of these heads. They are either due to vascular lesions, to epilepsy, to uræmia, to alcohol, or to hysteria. There is also to be considered the possibility of some such local lesion of the surface of the brain as a tumour, hitherto latent, or direct injury from without. But those we have most to consider are hysteria, epilepsy, uræmia and apoplexy, in all of which one gets true general convulsions or eclampsia. And I think I may here just remind you that the word *eclampsia* does not mean only puerperal convulsions, as some writers seem to think it should, but is a term meaning general convulsions.

In order to distinguish between different cases it is highly desirable, though it cannot always be carried out, that you should see the fits yourself. You are consulted from time to time about patients who have convulsive disorders, and in whom you find it very difficult to see the fits, simply because they are of short duration and occur at all sorts of times. It is perhaps impossible to see the fit when it happens. That being the case, you will not be surprised to hear how difficult it is sometimes to arrive at a right conclusion. One could give numerous instances of this difficulty, especially as between the epilepsy and hysteria in young women; and you will find how little trustworthy are the descriptions which are given you by the friends of the patient, for the purpose of discrimination.

Of course, there are certain rules that you are expected to follow with regard to these disorders. With regard to hysteria especially, one has the common belief that patients never hurt themselves, that they are not unconscious, that the tongue is never bitten, that they do not pass water and that the fits never occur at night. These are not all to be trusted. Certainly, I think, one must admit that the patients are sometimes unconscious, and that they may not remember anything about the fit afterwards. It is true that they do not show the complete loss of reflex, as a rule, that the epileptic patient does. On the other hand, they certainly do hurt themselves sometimes, and the fit may occur at night. In our patient, whose sex and age exempt him from the suspicion of hysteria, there are, of course, many things to be considered. It may be that he has got epilepsy. As a rule, no doubt, epilepsy begins some time in early boyhood, or the first fit may take place at the age of puberty or shortly afterwards. But it must be admitted that there are a number of cases of convulsive disorder that you do not include under any other head than epilepsy which occur later in life. Epilepsy is a possibility.

Uræmia, of course, is another possibility as a cause of convulsions in a person of this age: but though he has a trace of albumin in the urine, the occurrence of aphasia and the rapid recovery from the fit are unlike what occurs in uræmia.

Another possible cause of convulsions in a person of his age is some lesion of the vascular system of the brain, the obstruction of a vessel, as, for instance, by an embolism, or the rupture of a vessel, so that hæmorrhage takes place into the surrounding tissue—the usual cause of apoplexy.

Then also one must admit that alcoholic patients suffering from an acute or sub-acute alcoholism may have convulsive movements of a very deceptive kind. These movements have a nearer approach to hysteria than any other, that is to say, they are less rhythmical, much more purposive, much more is the patient likely to struggle and *do* things in the course of his

convulsive movements, than a patient who has pure epilepsy.

There is another condition that is not mentioned there separately, though it would be included under organic cerebral disease, and that is, convulsions in general paralysis of the insane. Such patients have convulsions at irregular times, and sometimes comparatively early in the complaint when the exact features of the disease are scarcely developed.

Which of all these is likely to be the case in our patient? We have this interesting point, namely, that three weeks before his admission, and before he had any fit, he had an attack of aphasia, or some mental disturbance. There is an account in the report to the effect that he was perfectly sensible, that he understood what certain men said, but was unable to answer or direct them, or to communicate properly or efficiently with them. I think the condition of aphasia is a point much against the attack being one of epilepsy.

Again, we have to consider whether an epileptic patient does commonly have two fits in the succession that this patient did. He became unconscious, and possibly he was convulsed—we do not know certainly. Then he partly recovered. Afterwards he came to the surgery and apparently wanted to speak, but could not do so correctly. At any rate, he had got his intelligence so far that he desired to speak. Then he had another attack of convulsions. In epilepsy the attack comes on almost suddenly in perfect health, but there is sometimes an *aura*, which is a subjective sensation and may not be manifest to the observers. Then the patient becomes unconscious, and almost at the same time has tonic convulsions.

The preliminary period of unconsciousness is very short; you may see this in cases of convulsions in the wards. A patient may be talking to you, or may be listening to you, and you may be looking at him without suspecting anything, when some movement takes place, perhaps of his face, or perhaps he turns his head over to one side in an unintelligible manner, or his eyes may turn up, or his arm may be raised into a rigid tonic position, and you scarcely realise at first that he is going into convulsions. After a short period of these tonic convulsions, the clonic convulsions begin in the parts affected. At the expiration of one and a half minutes at the most, the convulsions practically cease, and the patient, perhaps even then, may be recovering his senses, or he may be dull and drowsy, and stupid for some little time after that. And generally, I think, he does not have another fit immediately after that. But I think that what is the strongest argument against epilepsy is the occurrence of a perfectly independent attack of aphasia at a period three weeks before that; and it seems to me that it is much more likely that this condition was due to some defective condition of the cerebral circulation, some slight lesion of an artery in the neighbourhood of his speech centre and the motor convolutions, such as we know may occur in one of his age and mode of life, and in connection with bad arteries and renal disease. We are treating him chiefly on that basis. He is a patient who has probably drunk a good deal, and who will benefit by our low diet and laxatives, and simple plain food. In the course of time he will probably be in a better condition of health, and less liable to vascular disturbances of this kind.

The next patient I have to deal with is a man aged 23. He is an engineer, and was admitted for weakness of the left arm and leg, and for abdominal pain. "He had measles as an infant. When two years old patient had a fit, after which there was some loss of power in the left arm and leg. The weakness of the arm and leg grew gradually less, until, when nine years old, the patient fell into the Surrey Canal and was nearly drowned. He was kept in bed for eight or nine months subsequent to this accident, although he does not know why. On leaving his bed at the end of that period, it was found that his left arm and leg were considerably weaker than before the accident, so that the arm was nearly useless, and the patient walked with a limp, the loss of power of the arm being much greater than that of the leg. There appears to have been no visual paralysis, or trouble of the bladder or rectum, and never any loss of sensation. During the next ten

years the patient gradually recovered power in the weakened limbs so that he could follow his employment as an engineer, and the latter part of the time he walked without a limp," which rather implies that he walked during the greater part of that time somewhat imperfectly. "At the end of this time the patient met with another accident, falling heavily on the kerb on the left side. This, according to his account, resulted in the return of loss of power in the left arm and leg, although the loss of power in the leg does not appear to have prevented his walking. From that time onward the patient says there has been no improvement in his condition; indeed his symptoms were aggravated by the blows he received in the abdomen."

The chief points that I may refer to are these. He distinctly has weakness on the left side of the body and in the left arm and leg. There is very slight difference between the size of the right and left limbs. The greatest circumference of the left forearm is ten and a quarter inches, and that of the right forearm is the same; the left thigh is only a quarter of an inch less than the right, and the left leg is half an inch less than the right. The limbs all react properly to the galvanic current. There is slight spasticity of the left limbs, and the arm and leg are not quite free in their movements. The muscle readily contracts under your hand when you manipulate the arm. Thus there is weakness with a certain degree of spasticity, and a minute difference in the bulk of the limbs.

Now, here again very largely—because we have not been able to watch him throughout these twenty-one years—you have to rely upon his statement, and there is some little difficulty in coming to a satisfactory conclusion as to the exact state of affairs. We have the statement from his mother that he had a fit when two years of age, and that there was loss of power in the left arm and leg after that. One naturally asks, What is the common result of cases of this kind, in which there is the occurrence of a hemiplegic lesion in an infant or child? The probabilities are that the convulsion was started by a definite lesion in the right side of his brain in the motor convolutions, and that that lesion may have been a slight hæmorrhage or an embolism. Experience shows that if you get such a lesion of the brain, in infants or young children, the subsequent course of the hemiplegia is very often unsatisfactory. Some cases recover completely, but the greater number of the patients do not completely recover. They may move the limb, but they have impairment of power in the limb, and although they do not have the fixed contractions or contracture of the muscles with which we are more or less familiar in adults, they have very often the condition known as *athetosis*, a condition of involuntary contractions of different parts, especially the distal parts, of the limb. The word athetosis is intended to mean restlessness, and is derived from the Greek words ἄ (not) and τίθημι (I place). It means simply that the parts are not quiet. It seems to me an eminently bad term, and it is not in the least distinctive, because it is quite obvious that patients with chorea also suffer from an athetosis, that is to say, the parts are not kept quiet when they should be. I have not succeeded in finding a substitute for it, nor have I heard of any. *Athetosis* means irregular, spasmodic, involuntary movements, sometimes spontaneous, and sometimes started by voluntary efforts, which occur in the affected arm and leg, more often the fingers and toes, of a partially recovered hemiplegic patient.

The name was first given to the condition in two adults who had not a definite hemiplegia, but who had this mobile spasm or restless involuntary condition or movement only on one side of the body. That is, there was a hemiplegic one-sided occurrence of involuntary spasm without material loss of power. The name was subsequently extended to those cases in which children who suffer from hemiplegia in infancy recover imperfectly. The movement is sometimes only limited to a movement to-and-fro of the fingers; if the patient is trying to do anything the fingers move about a good deal. The fingers and toes are constantly working thus, and the patient may be in a continual state of trouble and annoyance. There are cases also in which you see enormous hypertrophy of the muscles as a result of the excessive movements. One case which I showed to the Clinical Society a long time ago, a young woman 23 years of

age, had an arm in size like that of a blacksmith as a result of a cerebral lesion in early youth.

There are other cases in which the lesion is, no doubt, much more extensive, cases in which children have had damage to the surface of the brain by compression of the head during forced labour, as a result of which may occur a condition of combined hemiplegia and paraplegia, so called diplegia spastica. I need not go into any detail about that, because the condition is so much beyond what can exist as a cause of the symptoms we see here.

The spasticity, I suppose, is principally the result of a loss of inhibition. It has been attributed by some to the irritation of a descending sclerosis, and by others to a loss of the inhibition which the highest centres should exercise on the lower. I think it is highly probable that in this patient the condition which he had from childhood has become permanent. It is very difficult to understand how the various injuries that he refers to since that time could have much aggravated the condition from which he is suffering. It is stated, first, that at nine years of age he fell into the water; secondly, that he fell on the kerb on to his left side, which ought not to have aggravated a left-side paralysis; and lastly that he has had a blow on the abdomen. These three accidents, according to our information on the subject, so very remote, do not directly explain the increase in his symptoms, which is said on each occasion to have followed. I think it is, on the whole, most likely that as we have before said, the condition has persisted from the very earliest time, and that he is really in the condition of a patient who has had a slight damage to the right side of his brain, and in whom there is a slight degree of paralysis or weakness with the spastic condition which is so likely to follow.

Reference is made in the report to certain *associated movements*, that is in his case, movements of the healthy limb, when he attempts to move the affected limb. I think these movements are allied to other phenomena which one sees in the infantile cases.

For the sake of classifying them, I have represented these associated movements as a form of partial convulsions, but associated movements are very common, and it is doubtful if we can regard them as all unnatural or morbid. It is a part of education to dissociate one's movements. Everybody knows how the youth when learning to write rolls his tongue about in his mouth, and I am not sure that some of us are exempt from it even late in life. We go on rolling our tongues and twisting our lips because we cannot dissociate these movements. You know how difficult it is to turn one hand round in one direction, and at the same time make a straight to-and-fro movement with the other; the tendency is to make a similar movement with both hands, and that is associated movement. It is much more easy to roll your hands in corresponding positions; which illustrates the close association that there is between the two sides of the brain. I may, further, instance the case of so-called *mirror-writing*. Most of us will realise, if we make the attempt, that it is easier to write with the left hand in a direction from the middle line outwards, than in the direction of ordinary right-handed writing: and this gives a result which is like ordinary writing reflected in a mirror. This is another illustration of associated movement. The complicated movements that your right hand has learned to make towards the right of the body can be best copied by the left hand moving to the left of the body. That is pure bilateralism, and is what we are made up of. If you come to think of these things it is not perhaps so very difficult to understand the association of movement in a case like this. I suppose one may regard, as the possible explanation of it, that when this patient tries to effect a movement with the right hand, there is an impulse sent across to the nerve fibres of the opposite side, which impulse is not properly inhibited in consequence of the lesion on the left side.

Finally, I should like to refer to the extraordinary case of a patient (H. L.) who visited us recently in the Clinical ward. He is now sixty years of age; thirty-seven years ago he had his head severely injured on board ship,

and as a result he has suffered ever afterwards from constant movement of the arm. The condition may be regarded as an extreme form of athetosis. The arm is constantly moving as a result of the violent jerking movements of the shoulder and arm muscles, and this is going on day and night. He always has his arm strapped to his side, and when he was showing himself to us in Clinical the other day, the clinical assistants will remember how anxious he was about his arm, begging them to hold it tight and not to let it go for a moment, as he knew so well the difficulty to be encountered in again obtaining control of it when it was once allowed free play. He was exhibited in 1881 at the International Medical Congress in London, and was seen by Charcot and other neurologists of that time. He has had portions of nerve excised from the arm, and many muscles of the forearm are atrophied in consequence. The question of operation on the brain has been entertained, but he has not consented to have anything done, because he says he cannot get a guarantee that the operation will not be followed either by death or some further extension of the lesion beyond that which he has already.

Case for Diagnosis.

A SINGLE, well-developed girl of 18, was admitted for a lump in the abdomen which reached up to the umbilicus. For three months before admission she had not been well, and after being treated by her doctor for influenza, she went to St. Bartholomew's and was treated for anæmia. She obtained a letter and went to a convalescent home, whence, as she had a temperature of 102·6° she was sent to Guy's. No history of anything except that her last period was very profuse, following seven weeks' amenorrhœa.

Condition on admission.—A well-developed, excited, well-nourished girl, complaining of no pain. She noticed the lump six week previously. It rose out of the pelvis and lay obliquely. It was a small oval tumour, lying with its axis directed upwards towards a point an inch to left of and below the umbilicus. It corresponded in shape with a pregnant uterus, which might be lying obliquely. It was not fixed, nor tender, not fluctuating, rather too dense for a pregnant uterus, and not in the usual position.

The suspicion of pregnancy was excited by her evasive and untruthful replies to enquiries about her menstrual history, but her mother gave the following account. That three months' amenorrhœa had been followed by a very profuse discharge of blood, with clots; that her daughter had been keeping company with an undesirable man.

No signs in the breast at all, a slight median line pigmentation. Per vaginam the hymen was torn and patulous. There was no blueness, no discharge, and no evidence of pregnancy. The lump bimanually could not be distinguished from the uterus; did not fluctuate but extended into the left lateral fornix and lateral fossa. Examination was rather difficult; constipation was present; nothing was felt on the right side. Her temperature in the next ten days never fell below 100°, but was not typical of anything like pus, typhoid or tubercle. Her respirations were always quiet; she had no pain. Her bowels were freely moved, making her more comfortable. At the end of ten days the uterus was thought to be separate from the mass and to lie over to the right side, and the mass was thought to be external to the uterus, but they still moved together. She was obviously getting worse and wasting, so operation was decided upon. Fluctuation was felt by some observers. Nothing abnormal was found at all in any other organ.

Pregnancy was suspected on admission, for the size and shape of the tumour, coupled with the evident distress and untruthfulness of the history, and for a day or so it was quite doubtful. The history was so unreliable that it seemed quite possible that an extra-uterine or left-horn pregnancy might be present. Later on it was clear that pregnancy was quite negatived, and the diagnosis lay between a suppurating ovarian and a pyosalpinx. The presence of pus was shown by the noticeable sweating, and the sallow increasing cachexia with persistent pyrexia. There was some vomiting two days before the operation, but no pain or constipation. The abdomen was opened and a large tense and angry cyst presented fixed and shut off by strong recent adhesions. It was cautiously aspirated and the pus was incredibly foul. Its size and foulness, and the enormous number of adhesions, deterred the operator from attempting to remove it, so it was opened with difficulty through the left fornix and a large rubber tube ligatured *in situ*. After prolonged irrigation about a pint of foul pus was evacuated and the cavity left fairly sweet. She was replaced on her back, the temporary dressing removed and the abdomen examined.

The aspiration wound had been closed by a circular purse-string and the position of affairs was that the cyst, which was now emptied, was firmly united to the small intestine, which was being dragged down. The adhesions as far as possible were separated and the uterus was found lying low down, pushed over to the right. Above it there suddenly emerged into view a tense hydrosalpinx, lying free among the intestines. This was about the size of a German sausage. This alone was rapidly removed as the adhesions of the intestine were too dense to remove without resection, and her condition was quite grave, in fact, the anæsthetist hardly thought she would get off

the table alive. She was infused with saline into the tissues, and the incision closed. Douglas' pouch was apparently closed by adhesions. She rallied, on return to bed, with saline enemata, and the fluid she required was given her and she did quite well. She passed no flatus nor motion; she passed her water; later sickness was persistent. She was comfortable and satisfied. She retained nutrients, but her temperature was subnormal and never rose. Twenty-eight hours afterwards her condition was as before, but her temperature was subnormal and the sickness, a copious green acid vomit, continued. The stomach was washed out with saline, and a lot of decomposing mucus and foul acid fluid not fæcal was removed. She felt very comfortable and was grateful for the relief. Her abdomen was not distended, moved freely and she had no pain. She slept after lavage five hours and never vomited again.

At eight o'clock on the morning of the third day she woke from five hours sleep' free from retching, but at nine o'clock her condition had changed. She looked seriously ill but nothing else was wrong. Her temperature rose to 99°, the first time since the operation, it had not been subnormal. She retained a large enema and was listless and apathetic. By one o'clock she had glided imperceptibly into coma, from which she never recovered. By seven o'clock her breath had the peculiar sweet odour, not of violets, that has been noticed in suppurative peritonitis. She had obstinate retraction of the head, conjugate deviation of the eyes, a fixed and glassy stare, no squint or localising lesion. Her abdomen was not distended at all, moved quite well, the stitches were free from any suspicion of suppuration. She retained all nutrients. Transfusion and bleeding were tried, but the veins were quite full and her colour was good to the last. She had a slight fit, and died with a temperature of 103°, at 2 a.m., just three days eight hours after the operation, after a most painful death scene, as her mucus death rattle lasted some eight hours and was heard over the entire ward and outside. She seemed in no pain or discomfort.

There was a suspicion that the tube might be blocked, and the coma the result of absorption, so it was changed under an anæsthetic at 3 p.m., but there was no discharge or obstruction to the drainage.

Intestinal obstruction from dragging on the adhesions, peritonitis, cerebral abscess, meningitis, toxic absorption, fæcal absorption, were all suggested. The urine was freely excreted and was of a dark chocolate colour, did not contain blood, pus, or albumen, and had no evidence of turpentine poisoning which was suggested from the retention of the turpentine enema.

Her nutrition was good, nutrients and sheep's serum were used. Her veins were full, her pulse good, strong and regular till the last four hours. She absorbed the nutrients and was never in any pain or distress. The peculiar odour reminded one of diabetes, but an experienced observer informed me that he had invariably noticed that smell in suppurative peritonitis, and that it was an invariably fatal omen.

(For Solution see p. 248.)

Obituary.

Edwin Stott.

The only death that has taken place in the twelve years' existence of the College occurred on Friday, May 30th, in peculiarly sad and depressing circumstances. Edwin Stott, who had recently been appointed Junior Charity, died by his own hand. What the real causes which led to this painful conclusion of a well-spent life were, will never probably now be known. He was throughout his career noted for his gentleness and self-effacement; he was modest, retiring, and conscientious to a degree. He took life and his sphere in life very seriously, and there can be little doubt that the ordinary anxieties and worries of responsibility had deeply impressed him. In particular, he was worried about his patients, and sensitive and self-conscious as he was, it may be, he feared he was not equal to his task. How untrue this was his success in private practice and the general esteem of his acquaintances and friends are sufficient evidence.

It was remarked that he was not himself, but none knew the bitter family disappointment that had clouded his return to Guy's; and sensitive and self-exacting as he was by nature, there can be little doubt that the worries of his work, coupled with disappointment, led him to such a rash and untimely end. He was widely known and universally liked. He had many friends and no enemies, and the sorrows of such a painful termination cast a gloom over the entire hospital and has excited our general and sincere sympathy with his bereaved family.

Pass List.

University of London, May, 1902.

M.B. EXAMINATION.

SECOND DIVISION.—H. Barber, J. Evans, D. Forsyth, F. G. Gibson, S. Hodgson, N. N. A. Houghton, M. J. Rees.

Papers by Guy's Men.

Myxœdema in Mother and Child. By S. W. MacIlwaine, L.R.C.P., M.R.C.S. — *British Medical Journal*, 24th May.

A Case of Perforating Gastric Ulcer: Laparotomy: Recovery. By W. H. Bowes, M.D. Lond., F.R.C.S.— *Lancet*, May 24th.

A Case of Multiple Abscesses in the Liver, secondary to Perforating Ulcer of the Stomach. By Staff-Surgeon E. R. D. Fasken, R.N.—*Ibid.*, 31st May.

On the Prevention and Treatment of Middle Ear Suppuration. By C. Herbert Fagge, M.S., F.R.C.S.— *Clinical Journal*, 28th May.

Passim.

PEACE has come at last; and to say that we are all most heartily glad is to state the truth in the barest manner possible. Of course, it should be a festival for great rejoicing, and no doubt it would have been, had the end come closely following the dark days at the beginning of the war; but now, after months of waiting, with the finish in sight, it was marked by little more than a sigh of relief by the vast majority. The removal of the great tension which elicited such an outburst of public feeling, and drove London mad with excitement when our troops first began to meet with victory is not comparable to the situation to-day. Although we have had losses occasionally, and some heavy losses during the past year, the issue has never been in doubt, and we only had to endure patiently; so now that the end has come we cannot raise the wild excitement that followed the relief of Ladysmith; but we are none the less moved by a feeling of great thankfulness.

FEW there be who have not suffered during the war, and we, at Guy's, can look back with deep regret at a number of our old friends, dead on the field of duty. Now that peace is declared, the moment has arrived when their services should be recognised. The feeling has often been expressed that the erection of a memorial to them should be deferred till the war was at an end, and it was only from the possibility of interest in the scheme lagging that it was decided a few weeks ago to put it into execution during the oncoming months.

THE meeting concerning the South African Memorial will be held on Tuesday, June 17th, in the Anatomical Theatre, when Dr. Taylor has promised to preside. We hope that a large number may be present, not only to elect a committee, or to deal with the funds as they think proper, but to do honour to the occasion. The fund for the memorial, as will be seen in another column, has grown considerably, and will reach quite respectable dimensions.

WE publish a selection of letters on the question, received during the last fortnight, and most of them favour the scheme for an out-door memorial. It is to be hoped that a final decision will be arrived at by the meeting, or, as we proposed some time back, that a small committee may be elected, with power to do the best possible. If one scheme accepted by the meeting is found to be impracticable on investigation, it should be in the hands of the committee to execute another. We quite agree with one of our correspondents, who suggests that the details of the scheme should be left entirely to the artist who is entrusted with the work.

MAY we draw attention to the letter from the secretaries of the South African Civil Surgeon's Dinner which is to be held at the Hotel Cecil, on Monday, June 9th. Tickets, price 10s. 6d., are to be obtained from the secretaries. Sir Frederick Treves is to be in the chair, and it is expected that Lord Roberts will be present.

THE opening of the Nurses' Home will take place on July 7th, when the Prince and Princess of Wales have graciously consented to be present. A large number of notices are being circulated to those who are interested in the Hospital, stating that invitations will be issued to those who require them, and we are asked to draw attention to the fact that they will only be sent to those who reply.

THE usual date of Prize-day is altered on account of the preceding function, and it will be held this year in October. We are rejoiced to hear that the Lord Mayor has consented to distribute the prizes on that occasion.

THE result of the recent London M.B. examination came as a great surprise and a disappointment to all of us, as only seven of our men were successful. Only a few years ago it was considered as safe as exams. can be made that a man who knew his work would get through, but we fear that this examination has gone the way of many others, in which chance plays too important a part, as the results of the last few

years will testify to anyone who knows the merits of the candidates. Although the result of the Final Fellowship was not altogether anticipated, Guy's did well, five out of eight men being successful.

IT is not a little curious now, when looking back to the time some few years ago, when clinical assistants in the medical and surgical wards were established to provide more clinical work in the 5th year, to remember that the GAZETTE of the day allowed the publication of trenchant criticisms, and to remember the feelings that the appointment of four Charities and four Assistant House-surgeons aroused, and the deliberate, forcible condemnation of the scheme that appeared in these columns.

IF any experiment was justified, it was that one, and the increasing appreciation of the A.H.S. is one of the most striking features of the time, and if it has done nothing else it has added the element of uncertainty—some say chance—to the appointment list; and whereas before, the A.H.S. became H.S., like the A.H.P. now develops into the H.P., now there may be six competing for the post.

IT occasionally works out curiously. It is a great disadvantage to be on with a good set of clinicals, and a great advantage to be on with a poor set, because, in general, each firm of clinicals averages the same percentage of residents as the others, so that an inferior man may by lucky incidence of appointment reach the resident's table while his superior in intellect has failed through strong contemporary competition. In the olden time this was not so, as if ploughed for A.H.S. the candidate was not put off with another A.H.S. but allowed to enter the lists again. However, it is pleasant to note the general approbation that our far-sighted and benevolent authorities have earned by their scheme, which was somewhat eyed askance originally.

FASHION in pastime is fickle, and it is inexplicable. Time was when the Shield, the Bicycle Blue Ribbon, and the Water Polo laurels as regularly returned to Guy's as the seasons went round. We are indeed well replenished with cups at present (*absit omen*), a striking contrast to the barren and deserted shelves of two years ago, and though we have more than our fair share and do not wish to repine, yet it would be a great feat to reclaim the Athletic Trophy, which later generations have never seen, though perhaps have fairly earned.

THE Council of the Clubs' Union have decided that it would be an advantage to have Telephone numbers inserted in future issues of the Year Book, and the Secretary of the Union will be glad to hear from any member of the Union who wishes to have his Telephone address appearing in the issue for 1902.

Two Doctors.

When the budding Æsculapius—I claim no meed of originality in the use of this term—when the budding Æsculapius has received the mercenary and alcohol-genetic congratulations of the hall porter, and has stood alone with the night breeze on the embankment; when he has resorted with his fellows in many houses of refreshment in the long Strand, and, on the morrow, consumed much beer with chance acquaintances in the club and in the "Ship," after a while he finds that his leisure hangs heavy on his shoulders and he looks around for profitable employment, which may add to his store of knowledge and the gravity of his purse. Perhaps, who knows, he may avoid the blandishments of locum tenency and pass the office of the Secretary to the Treasurer without becoming entangled in the pleasing meshes of a temporary engagement. Perhaps he may avoid this only to succumb to the allurements of the steamship agent. Admittedly he does not love the sea. The slightest up and down movement as the ship's bows take the rising wave produces qualms which are anything but pleasant; the lateral roll, when the foremast maps out geometric figures on the heavens and lee, and weather runners twang as they take and lose the strain of the mast's weight, has an effect which he can predict and imitate on shore, with absolute certainty. Yet there is something, an indescribable something, handed down from a remote forefather, which attracts him in spite of himself to a shipboard life, and he finds himself under agreement to cure the bodies of the crew and passengers of some steamship, foreign bound, for a ridiculously inadequate sum per mensum.

As a matter of course, seeing that the Line is reputable, he acquires raiment of a brass-bound nature, and with a gold-laced peaked cap, rests assured that he can look the part of a mariner however much his stomach may belie him. And after a time he finds that even he

can become accustomed to a plunging steamship, and that he can enjoy his meals though the dishes are anchored to the table by the rough weather fiddles. Also there are games, for the calmer days, in endless variety and of enchanting simplicity. Also the passengers, of the other sex. So he passes away a lazy six months or so and finally returns to his home richer in nought save experience and friendship. But there are other classes of steamships that require surgeons: units of "lines" which are rarely quoted and never telegraphed, plying to nightmare ports for trade and trade alone, with never a passenger for pleasure, and on the home run, God help him, many a forced passenger for his health; some of the human waste in the making of an empire. Lines where the consumption of firebars is out of all proportion to the speed of the engines, and where the Skipper knows the burial service by heart. The surgeons of two such ships stand out vividly in my memory to this day; types, both of them, of a species that still exists, tucked away in the backwoods of the medical profession.

We were outward bound when I met the first example. I was standing on the promenade deck, or perhaps it would be more accurate to say the narrow strip of planking that was so designated. We were a cargo passenger boat of the tramp class, maximum speed, under ideal circumstances, ten knots. Down in the well deck forward a patient mariner, with a sad and hungry face, was making fast the winch that had lowered our last ton of cargo. I watched his clumsy yet dextrous methods in a nasty sea-way, and became lost in pity for the man and his life. Suddenly I was made aware that I was not alone. My nose was the picket that first gave the alarm, reacting sharply to a strong vapour of alcohol that floated towards me. Cautiously, very cautiously, I turned for a better view of the distillery, and then made the acquaintance of my first type. He was a middle-aged man, with the gait and demeanour of senility. A wooden hulk with a scrap heap of condemned engines; arteries and stomach, liver and nerves—pathological specimens every one. He was dressed, I remember, in a faded and frayed suit of gray cloth, cut after the pattern of a frock-coat, greasy at the collar and grimed at each cuff, with a front stained and smeared with many droppings. Perched on his grizzled hair was a new cap with the house flag of the line worked on the band. Dirty linen and patched boots completed the picture. At first glance the thought struck me that this was some tramp who had stowed himself away on board; the next, when my eye caught the cap, dismissed this view and connected him remotely with the ship's economy, but it never entered my head for one moment that he was veritably the "doctor."

"Two of a trade, I think," he said, in broad Scotch-English. "I'm the doctor on this packet," he added, seeing by my face that I was hopelessly bewildered. And then he chatted amiably, at first of matters ephemeral, then later of his profession, and finally of his life. He made no confidences, and opened no secret cupboards, but he told me as plainly as man can the sordid story of his lifewreck. One had only to supply the links—the obvious links—in his chain of history, and the whole brutal story became manifest. Drink was the mainspring, and all the rest followed in regular sequence—the private practice which he abandoned many years ago, the hurried reference to a vague midwifery circle, likewise abandoned—in time—and then the many voyages on many steamers and many lines, but never a crack house flag among them.

I missed him for the next few days, and heard vaguely that he was ill in his cabin. Then he appeared again in his old seat, and I noticed that his drink was confined to water. The purser, in whom lies all the secret knowledge of the ship, whispered that the skipper had "stopped his wine bill," and hinted at the nature of his late illness. So he lived, a tremulous parched existence until the embargo was removed, and once more he stood forth ready to accept drinks. When I left the ship he had so far behaved himself with moderation, and seemed likely to create a record in his own life. But later the old inclinations proved too strong for him, and when I heard of him again, in a godless, tropical region, he was reaping the reward of a fortnight's trade gin—in irons. What became of him, whether he went out in the miasmic clutches of those evil rivers, or whether he once more made Liverpool, I know not, nor do I care.

The next man was of a different type, but yet with much in common. He was a tall, stout fellow of about forty years, with a fresh complexion, and gold eye-glasses hiding high myopia. In dress and person eminently respectable; but on close inspection, the shifting eyes and the weak mouth gave the clue to his present position. He was a ready talker, with much of the plausibility that an Irish nationality bestows. He professed a love for the free life of the sea, and a horror for the eternal monotony of shore employment. A general practitioner, to him, was the type of hopeless mediocrity and intolerable sameness. "I speak feelingly," he said, "for I have been through the mill." Then he went on to speak of the practice—his father's practice, to which he had succeeded, and which, after three years, he had abandoned for the life of a rover. Abandoned was the word he used, for, as he said with a laugh, there was nothing left to sell.

Two or three days after our first conversation I was sitting in the smoking-room in company with the captain, a conceited, ignorant, pompous old fool, destitute alike of tact and manners, when the doctor came in and requested a few words with the chief. The habitual tone of this mariner prevented me from remaining in ignorance of the subject of conversation, and I soon learnt that one of the crew had reported sick and had been examined by my Irish friend. His report was eminently satisfactory to the captain, who had apparently all along taken the attitude in which he was now strengthened by the doctor. "Very well, then, he'll go back to work at once. I'll have no skrimshankers in my ship." The doctor smiled

a self-deprecatory smile and rejoiced to be at one with his chief.

That same evening, while preparing for dinner, I had a short conversation with my stateroom steward. He was evidently burning to impart his news to someone, and preferentially to a sympathetic audience. "One of the firemen, sir, is sick. They say he's pretty bad. The old man made him do his spell to-day and he turned up at four bells." That was all, but it was an index of the general feeling forward. Someone had blundered, and it looked as if my weak-mouthed colleague was the culprit. The next morning at seven when he brought my morning tea, the steward's face shone with the light of triumph. "That fireman, sir, I told you about. Well, he's dead. He's to be buried at eight bells." Then he departed eager to carry the news to his other charges. Punctually at eight o'clock a small procession came aft with a shapeless mass in sail-cloth and deposited it on a plank which had been run out of one of the ports. Then the skipper appeared and the jangle of the telegraph bell from the bridge suddenly quelled the throbbing engines. Obedient to the helm, thrown hard over to starboard, the ship swung till she lay with her nose pointing a quarter of the compass off her course. A hurried gabbling of the Service, and the body of the unfortunate fireman slipped quietly into the placid sea. The ports were crashed to and another clang in the engine room sent us once more homeward bound. Too brief to be impressive, too hurried to convey the quiet sadness of a burial on shore; as his death, so his passing, brutal, simply brutal. Then the breakfast bell sounded and the skipper took his seat next the Important Passenger without the slightest trace of any feeling. "You've been busy this morning, I hear," said the Important Passenger. "A funeral, wasn't it?" "Only a fireman, that's all. . . . . Yes, porridge, and be quick about it." That was his requiem.

S.

Novelties.

MARACH.

Manufactured by the COLUMBIA CHEMICAL COMPANY.

THIS new preparation is in the form of a paste, and is intended to be used as a poultice or surgical dressing. It has been tried several times in the wards of this hospital, and has proved very successful in easing the pain of pleurisy, or inflamed joints. It is simple in application, the paste being beaten and spread over the part from $\frac{1}{8}$ to $\frac{1}{4}$ of an inch in thickness, and then covered with wool, one great advantage over the ordinary linseed poultices lies in the fact that it may be left on for 12 to 24 hours with continued relief, thus doing away with the great inconvenience of repeatedly disturbing the patient.

The "Nineteenth Century" Nurse.

(CONTRIBUTED.)

THIS series of articles has now nearly run its usual course. Public interest and attention is excited by an article, confident and seemingly well-informed, which, in a few resonant sentences, destroys the illusions (!) of a lifetime and lays bare the stern and unpleasant, and hitherto well-concealed realities.

This is followed by the justly indignant replies of the unfairly attacked and surprised authorities, and then the floodgates of "paterfamilias," "constant reader," "one who has suffered," etc., pour forth a muddy and back-eddying stream, till the editor intimates "that the correspondence must now cease."

That is the usual course in the silly season followed with much success by the respectable dailies, and at all times, in season and out of season, by the "half-penny rag," morning or evening; but it is but rarely indulged by the complacent and respectable monthly.

Be this as it may, it has occurred in the recent attack on nurses. The current number is wearisome and wandering. But there is by common consent much that is unsatisfactory—much that requires mending, if not *ending*, in the training, position and prospects of the trained or hospital nurse, and discussion is not to be contemned nor deprecated so long as it avoids random abuse, and does not display ignorance of essentials.

There is a far wider scope still for improvement in the conditions under which the public seeks to obtain, in its hour or dire distress and need, the invaluable assistance of sensible and intelligent assistance.

Had the unsatisfactory conditions and results been discussed with firmness and common sense, there would have been little to blame or object to, though the practice of intruding the washing one's dirty linen into other people's gardens is almost worse than merely displaying it in public.

But the real complaint that is voiced so materially and in such contradictory terms, is that of the patient's friends—the bugbear of the doctor, the plague of the consultant, and the sworn and increasing foe of the trained nurse.

The problems raised are multitudinous and complex. Speaking from experience, it may be said that a lady nurse in a small household is always pleasant, bearable and satisfactory, but still, with all that, is an abiding and vexatious restraint.

The whole difficulty arises in the fact that often the nurse is too good for the family, and more often *vice-versa*. In sudden engagements this must be so, and will be so, as the best nurses and most refined naturally shrink from nursing all comers—from barkeepers to countesses—and leave the great institutions to indulge their talents in other directions.

We are of opinion that the friends of the patients are the chief cause of worry. It will generally be found that the patients are satisfied in the nurse, but the

friends can no man tame, and it is as pitiable as it is unpleasant that their well-meant devotion and zeal is so often misspent and dangerous.

We suppose that now the attention has been turned to this question, we may expect as fierce an onslaught on the modern doctor to follow, but if it be so let us hope that our failings and deficiencies will be more fully heard and discussed in more level-headed and sensible language than the majority of the attacks we have referred to.

The doctor and nurse should visit the patient first, confer, and then the doctor should report progress to the relatives, stating his opinion and orders.

No one but the nurse or her representative should be allowed to *attend* as apart from visiting the sick. It is all but impossible if an inch is conceded to prevent the loss of the ell; for instance, if the friends give the patient the food he demands, or loosen the bandages, or obey his orders, it is but a short step towards solid good for the typhoid, or suppuration for the surgical.

The actual care of the sick is best entrusted to those whose position and knowledge enables them to refuse what is harmful. In medical meetings and in all professional gatherings, doctors pour out volumes on the subject, and it is well known that the hospital cures many a patient and rescues many a self-indulgent neurotic who is dependent on sympathy for his symptoms, and on the care of others for his neurasthesia and inertia from the life of chronic invalidism, that is only possible at home in unrestrained cases. Who has not seen at home, on the sofa, healthy people whose nerves or fancied disorders would be cured if they were treated by strangers in a hospital.

From every point of view, in a sick room, the doctor is responsible, and the whole of the arrangements should be and are under their control.

It may be said that any one can put up with a stranger in the gates for acute illnesses, but that for longer and chronic lingering diseases the presence of anything less than an angel in tact, in form, in voice, becomes distasteful. True, and naturally true. The best nurses weary in their professional zeal of chronics and require a change. Who then shall nurse the chronic? Answer. Get the nurse to train a relative, for chronic cases the emergencies are few and the teaching slight. Failing a relative, *e.g.*, the wife for the husband, train a servant of the nursery nurse class, or the male attendant of the household. The hospital nurse, unless old, is unsuited for the cases and undesirable.

Leaving aside the question of improvement in the training of nurses, let us tackle the points raised about private nursing.

The ideal method in illness is to call a doctor, and he naturally assumes the responsibility. The question of employing a nurse is raised by either, but the nurse should be engaged from the institution that either is acquainted with, or from personal knowledge (the doctor will know one if the patient does not). The responsibility of seeing the nurse is suitable rests on the doctor. If the nurse is suiting the patient the household must, except in extreme cases, put up with the discomfort, and if the patient and nurse get on there will not be much trouble usually in the family.

In acute cases, and it is for these alone that nurses are usually required, the discomfort of a stranger in the house will not last long and can usually be borne. It is interesting to observe that no case of the nurse failing to be capable and to suit the patient is referred to; it is all the cry of the friends.

The nurse's report to the doctor must be private, and the instructions must be definite and decided. If the doctor does not know what to order, then one who does should be employed. It is not the nurse's business to initiate treatment, though as often as not the highly trained nurse is as capable of suggestion in diet as need be.

More hopeless advice than that of the last article can hardly be imagined, we reproduce it:—"Speaking to mother, *wife*, or *sister*, one would say, make a point of being constantly in the sick room. . . . Of seeing the chart, and all the records kept of food, temperature, etc.; always be present when the nurse gives the doctor her report, and when he gives his orders. Make it your business to know that these orders are carried out, and if not find out why they are omitted."

The reverse, or nearly the reverse is what is necessary and practicable, and we do not speak without knowledge.

It boots little that the cases quoted are obviously rare and choice specimens, and that their claim to rank as cases of hospital nurses is unknown, or at least not revealed, neither does it matter that the remedy for the shortcomings complained of is often obvious.

We are so entirely at one with the writer when she says the demand has increased, because—

"People are becoming more and more alive to the evils attendant on amateur nursing methods," but the inconsistency of acknowledging the invaluable aid rendered by nurses and then expressly condemning them *all*, and assuring us that these painful cases are typical and not unique, does not appear to strike her.

It is the cry of that sorriest and most pitiable of human beings, the unintelligent emotionalist, whose large heart is wounded by suffering, but whose emotions and want of mental balance lead her merely to accentuate the sufferings which they would give worlds of devotion and self sacrifice to alleviate.

It is the educated counterpart of the Borough mother who cannot see that to feed a sick child on milk only is not a brutal starvation, but often the surest kindness.

Just as the poor may revile the open window, the daily washing, the enforced treatment, and the discomforts of antitoxins, so the educated and richer cannot understand that the doctor and the nurse may in the truest interests of the patient do much that they do not like and carry out things that the lookers on cannot understand, and that explanation is as useless as it is dangerous.

Let us briefly allude to the amazing article which gravely discussed who is responsible for the patient. It

is gravely discussed whether the doctor, the nurse, or the mother is responsible, and the extraordinary conclusion is arrived at, that the mother reigns superior to all three, and should preside at the meeting of them all, *being comparable to a hospital sister!* Ye gods!!! a sister presiding over the Staff, and the Staff nurse's consultation.

Presentation Day at the London University.

MAY 14TH, 1902.

MOST men at the hospital know about as much of Presentation Day at the University of London as they know of the University itself, to wit, *nil.* It is a standing matter of reproach that so few graduates appear to represent their hospital every year, the majority being quite satisfied to receive their degree by post, and let the reputation of the hospital take care of itself. Therefore, the Editor being short of copy and dishevelled,* and Presentation Day being of no interest to anybody who was not present, I am going to give some of my impressions of a day that ought to be the climax of a student's educational career.

Impression number one was that I was still at school. On arrival, after having fought for a cap and gown, we were all seated in two long rows facing each other in an empty room, and were told by Mr. M. J. M. Hill, Professor of Mathematics at University College, one of the meekest and quietest of men, with a low voice and a sad visage, to be good and keep quiet. Unfortunately, like the flamingoes at the garden party in "Alice in Wonderland" (the M.D.s especially) candidates would keep on getting up and walking about to look at the other flamingoes and order was hard to obtain; but eventually being quieted, we were given our marching orders, and amid loud chirping from countless lady B.A.'s, were told to remove our caps on entering the Great Hall (a commodious barn). This was the great chance for the coiffures, it being universally acknowledged that a small mortar board on the top of a large head of hair and a "bun," is both precarious and undecorative.

Arrived in the great hall we had some minutes to try and signal to fond mothers and relations, and to watch the incoming guests. The Chief Rabbi was billed to appear but we did not see him, but the Mayors of West Ham and Bethnal Green aroused the audience to a delirious pitch of excitement.

Impression number two was that if you did not know that the medical profession was an intellectual one, you would never think so if you saw them all assembled in mass. In many cases there was much more jowl than cranium, and a general air of "well fed-ness," which we do not associate with fine intellect. They behaved decorously, however, and talked in whispers.

The entrance of the Chancellor's procession was the "close" of the afternoon. The two salient features were the similarity between Professor Oliver Lodge and Lord Salisbury and the impassive attitude of Lord Rosebery in brand new Chancellor's robes, very heavily braided with gold, and with a small red rose in his buttonhole, he looked neither to right nor left, and sat down in the big chair like an automaton. The same extreme restraint marked his speech. His remarks on previous Chancellors, phrased in exquisitely choice English, was delivered in a slow, rotund manner, which must be a joy to every reporter. His only fault was the extreme brevity of his speech, for you could listen all the afternoon to such a perfect delivery.

After an "apologia pro vita suâ" on behalf of the University by Principal Rücker, a perfect stranger got hold of a list of the candidates, and began bawling out their names at a terrific pace. The mace on a table in the centre of the platform was very much in the way of the Presentors, who occasionally had some difficulty in finding their proper candidates to present and sometimes nearly presented each other. In fact, it was with the greatest difficulty that Miss Beale was restrained from presenting Dr. Taylor as the only successful candidate for the First Scriptural Examination.

Dr. Taylor found me alright and presented me, and Lord Rosebery said "*um—glum—glum*" very nicely in my ear, and I got back to my seat to find I had a bogus diploma in my hand as the real ones were not yet signed. Great consternation was caused among the ladies by a Guy's H.-P. tearing his up "coram publico." They thought the heavens would fall on such a blasphemer.

After a time the stranger's voice broke with calling out so many names so he gave it up, and Sir Michael Foster, in a lengthy speech, illustrated with both hands how he would dive off the platform if he had the chance. The mace and table protected him, however. The band started "God save the King," and every one had to go out, and thus in one hour and ten minutes 271 graduates of the University, beginning with John Atkins, M.B., Guy's Hospital, and ending with John Oakesmith D. Lit, had been crowned with academic laurels—four a minute, including speeches.

Impression number three was one of pity for countless girls and men with B.A. degrees hardly worth the paper they are written on for making a living, and leading only to teaching in small private schools and Board Schools; impression the fourth and last, was the urgent need of some comic interlude, *e.g.*, a patter song by the Chancellor, like his compeer in Iolanthe.

For the sake of history the following is a list of Guy's men who took their degrees on the 14th:—

M.B.—John Atkins, Robert Balderston, William Henry Bowen, Herbert William Brown, Geoffrey Clarke, Thomas Henry Bourne Dobson, Dudley George Greenfield, John Abbott Balding Hammond. William Gibson Parker, William Morton Robson, Louis Edward Stamm, Claude Tessier.

M.B. and B.S.—Kennet Bush Alexander, Henry Crewe Keates.

M.D.—Herbert Lightfoot Eason, Walter Henry Maxwell Telling (Gold Medal).

* A poor excuse.—ED.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial.

DEAR SIR,—I beg to enclose 10s. 6d. as a subscription to the South African Memorial Fund.

I am strongly in favour of the memorial being placed on the grass plot between Guy's and Hunt's Houses and of its being something after the style suggested by O. L. in the GAZETTE.—I am, yours faithfully,

G. BERTRAM MURIEL.

109, Scotch Street, Whitehaven,
26th May, 1902.

DEAR SIR,—I enclose Postal Order for 10/- for the fund which is being raised for a South African Memorial.

Whatever form the Memorial may take I hope it will be placed in the open.—Yours truly,

R. W. BASIL HALL, Surgeon, R.N.

H.M.S. *Grasshopper*, Queenstown,
May 27th, 1902.

DEAR SIR,—At the meeting of the Goblins' Club last night it was decided to send £5 5s. out of our funds to the South African Memorial Fund. I now have the pleasure of enclosing cheque for same.

You may know that poor Fitz-Hugh was our Secretary and Treasurer in 1898 and 1899, and both Sells and Onraët were members of this Club.—Faithfully yours,

PERCY F. HENRY.

79, King William Street, E.C.
May 29th, 1902.

DEAR SIR,—I enclose cheque for a guinea towards the South African Memorial Fund.

I should favour the choice of the out-door site suggested for the erection of the memorial, where it could be viewed by patients and visitors, as well as by all connected with the hospital.

It will, no doubt, be one of the sights which every Guy's man will wish to show his friends, and its erection in the Library would therefore be an obvious disadvantage to readers.—I am, dear sir, yours very truly,

T. BRICE POOLE.

53, Trinity Road, Wimbledon, S.W.,
May 29, 1902.

DEAR SIR,—I enclose a small but somewhat tardy subscription to the South African Memorial Fund.

As to the form the Memorial should take, if I might be allowed to make a suggestion, I should say, commission a thoroughly competent artist and leave the matter entirely to him. The efforts of the monumental mason, tempered by the criticisms of a committee of inexperts, are seldom, I fancy, crowned with the approbation of succeeding generations.—I am, dear sir, yours faithfully,

J. M. FORTESCUE BRICKDALE.

c/o G. White, Esq.,
39, West Park, Eltham,
June 2nd, 1902.

South African Civil Surgeons' Dinner.

SIR,—We shall be much obliged if you will announce that Sir F. Treves, K.C.V.O., will preside at the second South African Civil Surgeons' Dinner at the Hotel Cecil, on Monday, June 9th; that a large number have already applied for tickets, and that those who have not done so should apply to us as soon as possible. Guests are allowed. All who served with any irregular force in any medical capacity, whether qualified or unqualified, are invited.—Dear Sir, yours faithfully,

F. E. FREMANTLE,
C. GORDON WATSON, } Hon. Secs.

The College, St. Batholomew's Hospital, E.C.
May 25th.

South African Memorial Fund.

ELEVENTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	202	10	0
The Goblins' Club	5	5	0
Charles Higgens, F.R.C.S.	5	0	0
R. Balderston, M.B.	1	1	0
George Black, M.B.	1	1	0
B. N. Dalton, M.D.	1	1	0
J. M. Fortescue-Brickdale, M.B.	1	1	0
T. B. Poole, M.D.	1	1	0
Holland H. Wright	1	1	0
G. B. Muriel, M.B.	0	10	6
A. A. H. Partridge, M.B.	0	10	6
B. Rix	0	10	6
Surgeon R. W. B. Hall, R.N.	0	10	0
H. V. Hickman, M.B.	0	10	0
W. Bramley Taylor	0	10	0
H. S. Desprez	0	5	0
	£222	7	6

NOTE.—We regret to have given circulation to a serious misstatement. The belts used in abdominal sections in Queen and, we believe, in Bright, are made by Mrs. GODDIN, 18, Union Square, Newington Causeway, of, we believe, satin-gear, and the price for hospital patients is 10s. 6d., for private patients 13s. to 21s. according to the individual fancies.

Sport.

Cricket.

GUY'S v. BLUE MANTLES.

This game was played at Tunbridge Wells on Wednesday, May 14th, and ended in a draw. Guy's batted first. Barber and Langdale batted well, and added 128 runs for the 2nd wicket. For the Blue Mantles Rendle played a good innings. Scores:—

GUY'S.

H. Barber, c Barrow, b Kelsey	102
H. D. Wyatt, c. Munro, b Wilson	9
H. M. Langdale, c Havers, b Wilson	51
F. Morres, b Kelsey	6
E. L. Norton, st Barrow, b Kelsey	10
S. C. Bowle, c & b Havers	35
E. A. Collins, st Barrow, b Kelsey	6
G. N. Bartlett, c Stone, b Kelsey	7
J. Bookless, not out	10
A. L. Foster, c Barrow, b Havers	0
M. G. Louisson, c Barrow b Havers	0
Extras	13
Total	250

BLUE MANTLES.

H. Rendel, c Bartlett, b Bookless	81
W. Whatley, b Foster	14
C. Harvey, c Collins, b Foster	0
F. W. Mitchell, b Wyatt	6
L. D. Barrow, c Bartlett, b Bookless	19
J. T. S. Wilson, not out	9
C. Philcox, not out	2
Extras	12
Total	143

R. M. C. Munro, A. C. Havers, R. Stone, J. H. Kelsey, did not bat.

GUY'S v. SURBITON.

Played at Surbiton on Saturday, May 17th, Surbiton winning by 9 runs and 7 wickets. Guy's batted first on a sticky wicket, Brann bowling finely. On a wicket made easy by rain Surbiton hit off the necessary runs. Scores:—

GUY'S.

H. W. Wyatt, b G. Brann	9
H. Barber, b Brann	9
F. Morres, c Scarf, b Brann	12
E. L. Norton, b Brann	5
S. C. Bowle, c Thorburn, b Brann	9
A. E. Collins, run out	5
E. Morgan, c Howell, b Ross	1
A. M. Tolhurst, b Brann	9
J. Booklees, not out	2
J. Munro, b Ross	5
J. Gibson, c Fleming, b Brann	1
Extras	9
Total	77

SURBITON.

F. R. Lark, c Wyatt, b Morgan	31
C. Scarf, lbw., b Wyatt	13
A. J. Fleming, c Morgan, b Wyatt	9
G. Brann, not out	21
W. F. Thorburn, not out	6
Extras	6
Total	86

GUY'S 2ND XI. v. HOS.-SCHO.

Played at Honor Oak Park, on May 31st. Scores:—

GUY'S.

A. W. Long, c & b Bailey	32
A. H. Turner, c Clarke, b Bailey	27
K. V. Trubshaw, c Bowle, b Arnold	70
R. Willan, Sen., c Cooper, b Copsey	19
J. T. Hicks, b Bailey	24
W. H. Bush, run out	4
O. V. Payne, not out	21
E. W. Strange, not out	16
Extras	5
Total	218

F. C. Robinson, G. Allison, and G. Carlisle did not bat.

HOS.-SCHO.

Arnold, c & b Hicks	6
Jagger, b Hicks	2
Wood, b Carlisle	1
Copsey, b Hicks	0
Bailey, b Carlisle	22
Cooper, c & b Hicks	2
S. C. Bowle, not out	19
Clarke, c Turner, b Carlisle	2
Cann, b Hicks	0
Bush, c Bush, b Carlisle	0
Pelling, c & b Trubshaw	8
Total	62

GUY'S 3RD XI. v. ENFIELD LOCK.

Played at Enfield Lock and ending in a win by 18 runs. Scores:—

GUY'S.

	1st Innings.	2nd Innings.	
T. R. Harvey, b Hammond	9		
F. N. Fox, b Miller	0		
J. F. Smalley, b Hammond	0		
M. R. Smith, b Hammond	7		
H. G. Gibson, b Hammond	11		
G. Russell, b Miller	3	not out	23
G. N. Bartlett, run out	2	not out	20
H. H. Moyle, not out	12	c Miller, b Alfrey	27
W. H. Miller, c Miller, b Hammond	5	b Hampton	11
P. D. Macgowan, run out	0	c Alfrey, b Miller	6
Extras	5		4
Total	54	3 wkts.	91

ENFIELD LOCK.

C. Weble, run out	0
C. Miller, b Miller	0
H. Conn, b Miller	5
T. Alfrey, b Miller	7
F. Hampton, c & b Russell	3
Bentley, c Fox, b Miller	0
Hammond, c Moyle, b Russell	13
Dudley, c Fox, b Miller	3
J. Matthews, not out	0
W. Matthews, b Miller	0
Extras	5
Total	36

GUY'S 3rd XI. v. CHRISTCHURCH A.

Played at Woodside Park and won easily by 4 wickets and 109 runs. Fox played a good innings of 51, and Miller and Russell disposed of our opponents' batsmen very easily. Scores:—

GUY'S.

T. R. Harvey, b Newman	13
H. G. Gibson, c Grey, b Newman	0
F. N. Fox, c Reid, b Newman	51
H. H. Moyle, c Smith, b Calcat	23
G. Russell, c Smith, b Calcat	3
M. G. Louisson, not out	22
H. O. Brookhouse, b Reid	6
J. T. Smalley, not out	1
Extras	9
Total, 6 wickets	128

Innings declared.

W. H. Miller and G. N. Bartlett did not bat.

CHRISTCHURCH.

E. Morrison, b Miller	14
A. P. Smith, st Louisson, b Miller	1
G. Reid, b Miller	0
W. Newman, c Bartlett, b Russell	0
F. Calcat, b Russell	1
G. Holliday, b Miller	0
— Hughes, c Louisson, b Russell	0
B. Fisher, c Smalley, b Russell	1
H. Gray, c Russell, b Miller	0
— Baxter, not out	0
— Ely, c Gibson, b Miller	0
Extras	2
Total	19

GUY'S 3RD XI. v. CAMBERWELL HOUSE ASYLUM.

Played at Camberwell House, and ending in a win for our opponents by 15 runs. Scores:—

GUY'S 3RD.

F. N. Fox, b Turner	2
T. R. Harvey, b Lavers	7
H. H. Moyle, b Lavers	0
H. G. Gibson, b Lavers	11
J. T. Smalley, b Turner	0
G. N. Bartlett, b Turner	5
G. Russell, l b w, b Lavers	5
W. H. Miller, b Milton	19
H. O. Brookhouse, c Serjeant, b Mitchell	2
H. O. Vernon Taylor, not out	1
P. D. Macgcwan, run out	1
Extras	10
Total	63

CAMBERWELL HOUSE.

Dr. Lavers, c Fox, b Bartlett	3
Dr. Serjeant, b Russell	15
M. Jole, b Bartlett	2
G. Raymond, b Moyle	7
M. Robinson, b Smalley	14
— Parsons, b Bartlett	9
C. E. Mitchell, b Moyle	1
— Stringer, b Moyle	5
— Milton, b Moyle	0
F. Raymond, c Vernon Taylor, b Moyle	9
— Turner, not out	0
Extras	13
Total	78

Guy's Hospital Lawn Tennis Club.

Owing to rain our match v. Kent on Saturday, May 10th, and v. Blackheath on Saturday, May 17th, had to be abandoned.

GUY'S v. GRAVESEND.

On Saturday, May 24th, we played our first match v. Gravesend, on their ground, and the result was a win for Guy's by 6 events to 3.

E. N. Jupp and F. W. M. Palmer v. T. G. S. Castley and S. E. Penman, won, 6–2, 2–6, 6–2; v. L. Bridgland and B. C. Apps, won, 6–1, 6–3; v. T. M. Boorman and E. Penman, won, 6–1, 6–4.

H. C. Winckworth and A. Zorab v. Castley and Penman, lost, 5–7, 3–6; v. Bridgland and Apps, won, 6–3, 6–1; v. Boorman and Penman, won, 6–4, 6–0.

P. C. Bent and C. D. Pye-Smith v. Castley and Penman, lost, 2–6, 3–6; v. Bridgland and Apps, won, 6–3, 6–1; v. Boorman and Penman, lost, 1–6, 2–6.

GUY'S v. WANSTEAD.

On Saturday, May 31st, this match was played at Wanstead. Guy's lost by 4 events to 5.

E. N. Jupp and F. W. N. Palmer v. Muir and Lawrence, lost, 4–6, 4–6; v. Mitchel and Clarke, won, 6–4, 4–6, 6–4; v. Hatton and Goldie, won, 6–0, 6–1.

H. C. Winckworth and C. J. Pinching v. Muir and Lawrence, lost, 2–6, 6–4, 4–6; v. Mitchel and Clarke, lost, 5–7, 3–6; v. Hatton and Goldie, won, 6–1, 6–1.

A. Zorab and C. D. Pye-Smith v. Muir and Lawrence, lost, 0–6, 4–6; v. Mitchel and Clarke, lost, 3–6, 4–6; v. Hatton and Goldie, won, 4–6, 6–4, 6–1.

B. H. Wedd and T. C. Lucas are both unable to play for us at present, which considerably weakens the team.

F. W. M. Palmer and A. Zorab both play a good game, especially Palmer, so if Wedd and Lucas show their form of last season the team promises to be stronger than it has been for some years.

C. J. Pinching has been elected Captain of the 2nd VI. during A. Wylie's illness.

The usual tournaments will be held. Singles (handicap), Doubles (handicap), and Singles (open), for the Lane-Washbourn Cup, the winner to play the holder (T. C. Lucas).

Should there be any new men who were unable to play in the trial match, and would like to play for the Hospital, will they send me their names.

E. N. JUPP (Captain).

Appointments.

CIVIL.

FREMANTLE, FRANCIS E., M.B., B.Ch. Oxon, M.R.C.P., D.P.H., has been appointed County Medical Officer of Health to the Herts County Council.

HOPKINS, F. GOWLAND, M.B., B.Sc., has been appointed an examiner for the Gedge Prize in Physiology.

HOWARD, WILFRID, L.R.C.P. Edin., M.R.C.S., has been appointed District Medical Officer for the parishes of Old and New Buckenham, and also Public Vaccinator for the same parishes.

STEWARD, FRANCIS J., M.S., F.R.C.S., has been appointed an Assistant Examiner in Surgery to the Apothecaries' Society of London for a period of four years, *vice* L. A. Dunn, M.S., F.R.C.S., who retires by rotation.

WALLIS, H., L.D.S. Eng., has been appointed Dental Surgeon to the Humber Training Ship *Southampton*, Hull.

WORTHINGTON, SIDNEY, M.D. Lond., F.R.C.S. Eng., has been appointed Honorary Physician to the Chesterfield and North Derbyshire Hospital, also to be H.M. Certifying Factory Surgeon for the Chesterfield District.

NAVAL AND MILITARY.

Staff-Surgeon E. P. MOURILYAN, R.N., is appointed to the *Retribution*.

Lieutenant H. B. FOSTER, I.M.S., is posted to the Punjab.

Captain GEORGE BLACK, M.B., having relinquished his temporary commission for service in South Africa, is granted honorary rank in the army with permission to wear the uniform of the Royal Army Medical Corps.

Surgeon-Lieutenant ARTHUR S. WOHLMANN, M.D., 1st Devon and Somerset Royal Engineer Volunteers, resigns his commission.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICE.

H.R.H., HASTINGS.—Little information could be gained from the tissue elements of this thin sputum, as it was largely decomposed by the putrefactive bacteria present. In suitably stained films the tubercle bacillus was found in fair numbers.

X.Y.Z., HASTINGS.—This was a thin comparatively non-purulent sputum, in which the tubercle bacillus could not be detected.

C.F.W., HORLEY.—This was a purulent sputum containing a few putrefactive organisms. The tubercle bacillus was not found.

H., RAMSGATE.—This was muco-purulent sputum, but the tubercle bacillus could not be found in suitably stained portions.

PATHOLOGIST

Solution to Case for Diagnosis.

Post-mortem.—The cyst was empty and collapsed. It was in size about six inches long, with rough thickened walls, lined with pyogenic membrane. The dense adhesions had caused a considerable dragging by bands on the small intestine and stomach. The cyst was a tubo-ovarian, nothing more definite could be made out. The drainage tube passed through Douglas's pouch where there was a small amount of local peritonitis, probably insufficient to cause death, as it showed no tendency to spread and was being drained. The ventricles of the brain were recently and acutely dilated and the condition was thought to be one of acute inflammation of the ependyma, but the cause of death is still rather obscure. The drainage was quite free.

Birth.

GOADBY.—On May 16th, at the Mall, Wanstead, the wife of Kenneth W. Goadby, D.P.H. Camb., L.D.S. Eng., of a son.

Death.

LOE.—On April 20th, at Chapeltown Road, Leeds, James Scarborough Loe, M.R.C.S. Eng., L.S.A., in his 71st year.

ED.—D. G. G.

Contents.

	PAGE
TUBERCULAR PERITONITIS: Clinical Lecture by Dr. Hale White	249–253
PAPERS BY GUY'S MEN	253
CASE FOR DIAGNOSIS	253
DENTAL PRIZES	253
CORRESPONDENCE: South African Memorial Fund; Degrees for Conjoint Men; Great Walking Match in Germany	254–255
PASS LIST	255
TYPES OF MEDICAL STUDENTS	256–257
THE HEREAFTER	257–258
NURSING NEWS	258
APPOINTMENTS	258
SOUTH AFRICAN MEMORIAL FUND: Twelfth Subscription List	258
PASSIM	259–261
IN THE MEDICAL WARDS	262
REVIEWS	263
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	264
SPORT: Guy's Hospital Athletic Sports. Cricket—Guy's v. Wanderers; Guy's v. London County C.C.; Guy's v. Reigate; Guy's v. R.I.E.C.; Guy's v. Middlesex Hospital—Second Round Hospital Cup Ti; Guy's v. Hampstead; Guy's 2nd XI. v. City of London School. Lawn Tennis	264–268

Calendar of Coming Events.

June, 1902.

Sat. 21.—Messrs. Symonds and Steward's take-in; Drs., H. C. Winckworth and J. S. Cooper; Cl., W. H. Bowen.
G.H.C.C., I., v. Past, home.
II., v. Alleyn, away.
III., v. Old Golfeians, away.
G.H.L.T.C., Past v. Present, home.

Mon. 23.—1.15 p.m., Clinical lecture by Mr. Steward.

Tues. 24.—G.H.C.C., I., v. Hornsey, away.

Wed. 25.—G.H.C.C., II., v. St. Thomas's, away.

Thur. 26.—Coronation Day.
Messrs. Lucas and Lane's take-in; Drs., J. T. Hicks and N. I. Spriggs; Cl., H. W. Brown.

Fri. 27.—Bank Holiday.

Sat. 28.—G.H.C.C., I., v. Kensington Wanderers, home.
II., v. Reigate Priory "A,"
III., v. Quernmore School, away.

Mon. 30.—1.15 p.m., Clinical lecture by Mr. Targett.

July

Tues. 1.—October Appointment List opened.

Wed. 2.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. Gravesend, away.
II., v. Kingston Hill, home.
G.H.L.T.C., v. Staff, home.

Thur. 3.—Second Conjoint Examination begins.

Fri. 4.—1.15 p.m., Clinical lecture by Mr. Fripp.

Sat. 5.—G.H.C.C., I., v. Enfield, home.
II., v. St. Bart.'s. "A," away.
III., v. Syntax, away.

Guy's Hospital Gazette.

JUNE 21, 1902.

Tubercular Peritonitis.

CLINICAL LECTURE BY Dr. HALE WHITE.

(For the shorthand notes of this lecture we are indebted to the Editor of the CLINICAL JOURNAL*).*

GENTLEMEN,—Before going over the case which will form the subject of to-day's lecture, perhaps I had better tell you exactly what tubercular peritonitis is. It is a peritonitis set up by the tubercle bacillus, and can be easily produced in certain animals by injecting tubercular sputum into the peritoneal cavity. It is very rarely pure infection; before long other micro-organisms are associated with the tubercle bacillus.

Clinically it appears to be much more common in women than in men, but whether that is so is doubtful, for post-mortem experience indicates that the two sexes are affected almost equally. The matter, however, is of small importance, as tubercular peritonitis occurs frequently in both sexes. The frequency of the disease appears to vary in different parts of the world, for different authors give the percentage of deaths due to tubercular peritonitis as varying between 1¼ and 16 per cent. The higher number was obtained by Borschke, who, in 2450 autopsies, found 1393 cases of tubercle, and of these 226 or 16 per cent. had the peritoneum affected. Most morbid anatomists will tell you that primary infection of the peritoneal cavity by the tubercle bacillus is rare. Wilks and Moxon doubt, however, whether it is as rare as most people think. Be this as it may, all are agreed that a frequent source of infection is tubercle of the female genital organs. The disease varies very much in its frequency at different ages. Bottomley gives the following:

Under 10 years of age	30	cases.
10 to 20 "	112	"
20 to 30 "	137	"
30 to 40 "	122	"
40 to 50 "	93	"
50 to 60 "	31	"
60 to 70 "	11	"
Over 70 "	2	"
	538	"

Before you can understand the clinical symptoms you must have a good mental picture of the post-mortem condition. It is remarkable that tubercular peritonitis is so rare in comparison to the frequency with which sub-pertioneal tubercles are found underneath tubercular ulcers of the intestine. In the simplest cases of tubercular peritonitis you will see a number of grey tubercles none of them larger than swan shot, scattered over the peritoneum. They are found mostly under the diaphragm, and are rarest over the intestine. In such a case as this you will often find much fluid in the peritoneal cavity. In the most common form of tubercular peritonitis the striking thing is the enormous mass of adhesions; all the abdominal organs may be got out of the abdomen as a solid whole, as though they had all been fixed by having plaster of Paris run into the abdominal cavity, but the abstraction of them is by no means easy, for there are many adhesions to the abdominal wall itself. I have in such a case spent a couple of hours trying to dissect out the intestine from the matted mass, and then given up the task as hopeless. When a cut is made across this mass, a number of sections of the gut are seen, and they do not collapse when they are empty, for they are held open by adhesions. The intestinal walls are much softer than usual, so that they are torn in trying to get the intestines out. Among these adhesions there are numerous cavities containing fluid which may be purulent, and these abscesses commonly discharge themselves into one or more adjacent pieces of intestine, so that all sorts of fistulous communications are formed, and sometimes such a collection discharges externally on the one hand, and into the bowel on the other, so that there is a fæcal fistula open externally. In cases in which the adhesions are less marked, although extensive, the omentum is commonly puckered up and thickened, so as to form a transverse tumour lying across the abdomen just below the transverse colon, and various other masses of the thickened peritoneum occur in different parts of the abdomen. The peritonitis may be entirely fibrous, but caseous masses are commonly present, and the mesentery is often so puckered that the intestines are drawn back to he spine. Usually not much fluid is present in these cases, and it is commonly loculated. It varies in consistency, but is usually turbid and not rarely purulent; it may contain blood. The abdominal lymphoid glands are usually caseous, but you must not suppose that the enlarged caseous mesentery glands are often felt during life. When masses supposed to be these glands are felt, it nearly always turns out that they are really hard masses of peritoneum affected by tuberculous disease. You will find cirrhosis of the liver frequently associated with tubercular peritonitis.

Now I will give you the particulars of the patient that forms the subject of this clinical lecture. He is a young man aged nineteen, who came into the hospital on April 24th, stating that for about a fortnight he had been out of sorts suffering from abdominal pain, and lately felt so ill that he had not been able to do his work. His bowels had been irregular. On admission his temperature was 103°; he complained of no pain except in the abdomen, especially in the neighbourhood of the umbilicus; his breath was very foul; his tongue was covered with a light brownish fur; the abdomen was tumid and distended, it moved with respiration; no spots were seen. On palpation it seemed abnormally resistant, the spleen could not be felt, the front of the abdomen was resonant all over, there was tenderness on percussion over the umbilicus, and there was dulness in both flanks, which disappeared when the patient turned over. In the right axillary region there was an impaired note on percussion. No Widal reaction could be obtained, and the report on May 4th says that the abdomen was gradually getting more distended; there was more fluid in it. No typhoid spots had been seen. There was some dulness at the apex of the left lung. On May 9th, as the abdomen was still distended, the patient was seen by Mr. Dunn with a view to operation. It was also discovered that he had fluid at the base of his left lung; this was aspirated, three pints being drawn off. On May 11th a pleuritic rub was heard on the right side of the chest. On May 14th Mr. Dunn opened the abdomen just below the umbilicus. The peritoneum was found to be very thick, and

when opened a quantity of serous yellowish fluid gushed out. The intestines were matted together, and tied down to the posterior abdominal wall. The abdominal cavity was flushed out with warm sterilised water, and the wound was then sewn up. For about a week after the operation the patient seemed a little better, but then the temperature began to mount up again, and from then till now it has ranged about 101°, and the signs of tubercle in the chest have increased considerably.

I will now tell you something more about the symptoms. In the first place this man illustrates that the disease may be met with in adults, though it is a common impression that it is chiefly found in children. He also illustrates that, although it is not often primary in the abdomen, it is first noticed there. The early symptoms are that the patient becomes out of health and languid, his appetite is poor, he suffers from indigestion, irregular bowels, sometimes constipation, sometimes diarrhœa. He complains of abdominal pain, the tongue is furred, and he notices that the abdomen is distended. It is then discovered that his pulse is more rapid, his temperature is up a little, and he may sweat at night. Gradually all the above symptoms become worse, the abdomen more distended and particularly tympanitic; the reason for this being that the bowel is easily paralysed in this disease, gas collects in it, and makes the abdomen tympanitic and distended. If fluid is present, as it was in our patient, there is dulness in the flanks, and if the fluid is not shut in by adhesions this dulness shifts when the patient is shifted. By now the thickened omentum can be often felt transversely across the abdomen, the abdomen is lumpy, the umbilicus prominent and red, the patient anæmic, he loses weight, and his pulse becomes more rapid and his temperature higher. Later on, as our patient shows, all the above symptoms become worse; he becomes very wasted, the skin is shrunken, dry, and brown, and there are few things more striking in medicine than the extreme distension of the abdomen in marked contrast to the general wasting. The anæmia becomes profound, the feet swell, and slowly the patient sinks.

The only details that I need call your attention to are in connection with the abdomen. The condition of this will obviously be very variable in accordance as to whether it is distended by fluid, gas, or both. Adhesions, too, must make the state of the abdomen different in different cases. You must never forget also that loculi form, and they make the detection of fluctuation very difficult. You can sometimes press the fluid from one loculus to another, when you will get a gurgling sound. Another thing to remember is that you may find the fluid sometimes as much in front of the abdomen as at the sides. This is because the mesentery shrinks and drags back the intestine. Then, too, because the amount of gas in the intestine varies very much from day to day, the ease with which you will feel the omentum and the lumps of tuberculous matter will vary as well. Then, too, never forget you may get a fæcal fistula, and if this occurs it is always, or almost always, at the umbilicus; but apart from a fæcal fistula, the umbilicus is often very prominent, and it may be red. Peritonitis, too, may make micturition difficult. With these patients the appetite is often voracious, and they have most extraordinary likings for out-of-the-way articles of food; they suffer much from constipation and diarrhœa, and their motions are foul.

Some authors have classified the cases into acute and chronic, and have subdivided the chronic into fibro-caseous, ascitic, and fibrous.

It is, however, very important for you to remember that the groups merge much into each other, and further, as time goes on, a case that at one period of its history would have been placed in one group passes into another.

With regard to the complications we have no time to say anything about tubercle in other organs, and we must therefore restrict ourselves to the abdominal complications. Of these by far the most important is a fæcal fistula, and I have already explained to you how this is formed, and that it occurs usually at the umbilicus; it is more frequently seen in children than in adults. The second complication is that a fistula may form between adjacent parts of the bowel in much the same way as a fæcal fistula forms

externally, but fistulous communications between adjacent parts of the bowel are only diagnosed when the communication is between the jejunum and the colon. Then as the food short-circuits, and so does not pass through the greater part of the intestine, the patient wastes very rapidly, and much undigested food is found in the motions.

The third complication for you to bear in mind is intestinal obstruction. This may be due to a band, but this is rare; by far the most frequent form of intestinal obstruction following tubercular peritonitis is that which was first described in the "Guy's Hospital Reports" by Dr. Fagge as obstruction due to compression and traction. These words exactly tell you what happens, for owing to the contraction of the tubercular peritoneum it compresses the gut against the back of the abdomen, and at the same time the shrinking mesentery draws it down to the back also. Very slowly and very gradually therefore intestinal obstruction supervenes in these cases, and naturally it forms one of the most difficult varieties of obstruction to treat.

The diagnosis of tubercular peritonitis divides itself into two stages; in the early stages it is difficult to diagnose from any slow wasting disease in which the patient gradually loses health, but it is very important to remember that abdominal pain usually puts us on the right track, and whenever you have before you a patient at the age at which tubercular peritonitis is most common, and who is slowly getting out of health and losing flesh, and complaining of abdominal pain, you must always bear in mind the possibility of tubercular peritonitis.

The other condition from which it is difficult to diagnose it in its early stages is typhoid fever, and that difficulty presented itself in the patient before us, for he did not give a long history, and he was seriously ill when he came in; but, as in him, the disease soon declares itself one way or the other, for you either detect signs of peritonitis, as we did in his case, viz., the fluid in the abdomen, or, on the other hand, you get the well-known symptoms of typhoid fever. Occasionally, but very rarely, you may tell the two diseases by observing that the temperature is higher in the morning than in the evening, this pointing to tubercular peritonitis. In the latter stages the difficulties of diagnosis always takes the shape of determining what is the cause of ascites. That we cannot go into to-day, but I would remind you that if you decide the ascites is encysted, then it is almost certainly tubercular. Further, feeling the thickened omentum passing transversely across the abdomen is very strong evidence that the case is one of tubercular peritonitis.

The prognosis is unfortunately bad, and the points to which you must direct your attention in estimating it are, first of all, you must find out if there is tubercle in other organs, and this may quickly determine the prognosis, as, for example, if there is tubercular meningitis.

Severe gastro-intestinal symptoms may too quickly determine the prognosis, for it is obvious that if the patient is suffering from severe vomiting and diarrhœa which you cannot check, he will soon go downhill. Then, too, severe toxæmic symptoms, such as profound anæmia, great wasting, high temperature, rapid pulse, and albuminuria are all bad. Whatever the cause may be, loss of weight is extremely bad.

Again, these patients always do badly if they have been taking too much alcohol, or if they are suffering from active syphilis. The cases in which there is a fæcal fistula never do well, and speaking generally the prognosis is much better just in proportion as there is a large quantity of ascitic fluid present in the abdomen.

The treatment naturally divides itself into general and local. The general treatment is such as you would apply for tuberculous disease in any part of the body. The patients should have abundant fresh air day and night. You should send them into the country, where they can lie out of doors all day, and have their windows open all night. You should feed them up with plenty of good food, and clinical experience and experimental work both show that these tubercular patients do better upon plenty of farinaceous and fatty food than upon proteids. In England it is customary to apply some mercurial ointment to the abdomen, and that is best done by taking equal parts of lanoline and the pharmacopœial ointment of the oleate of

mercury, smearing them on a flannel binder, and fastening this round the abdomen. I myself think that this does some good, but how I do not know. In France it is customary to apply iodine locally.

Passing now to surgical treatment, all authorities are agreed that laparotomy is much more reliable than puncture. After the abdomen has been opened some surgeons wash it out with boiled water, others use weak antiseptics, others dust iodoform on some parts, others excise caseous nodules, and some take away the Fallopian tubes if the genital organs are tuberculous; but as all surgeons appear to get equally good results, it seems clear that the chief point is merely opening the abdomen; but why this should be so no one has satisfactorily explained. The points for you to beware of particularly are that the intestines are very soft, so that you may easily tear them; the adhesions may be very numerous, or it is difficult to get into the peritoneal cavity at all, and you must be very particular not to do anything that may lead to the formation of a fæcal fistula. Experience has shown that it is better after the operation to sew up the abdomen rather than to put in a drainage tube, and probably it is wise not to take away the tubercular female genital organs unless their removal is particularly easy. The mortality from the operation alone is from 2½ to 3 per cent.

Now you will want to have some guides as to whether you should operate in any particular case. In the first place, never operate if the tubercular peritonitis is merely part of an acute general turberculosis. In the next place, never operate if there is already a fæcal fistula, for the presence of a fæcal fistula shows that there must be numerous adhesions, and you will in all probability not be able to get into the peritoneal cavity at all. Next remember that you will get your best results in the cases in which there is most fluid present. It is quite true that those are the cases which will do best whether you operate or not, but on the other hand, they are just the cases in which the risk of operation is exceedingly small, and therefore, in them it is probably wise to open the abdomen and let the fluid out. Certainly you should do so if sending the patient away into the fresh air is impossible, but probably the best thing would be to open the abdomen, let out the fluid, and then send the patient away into the country. The worst results are obtained when there is little or no fluid in the abdomen. Therefore, in these cases you certainly should not open the abdominal cavity. Localised collections of fluid should be dealt with on the same principle, but you should be very wary of touching them because the very fact that the fluid is localised shows that there are many adhesions, and shows it is not the class of case that will probably do well. Never incise the prominent umbilicus that is so often met with in these cases, for it very often means that there is a tubercular abscess under it, and sooner or later this bursts into the bowel, and if you have previously opened it you have a fæcal fistula left. Another important point is that if there is already a fæcal fistula formed, do not on any account try to deal with it surgically. I have seen the most disastrous results follow, and I have never seen any good done. In talking to the friends about the operation it is only fair to them to say that while the immediate effect of an operation is often good, nevertheless the symptoms not infrequently return. You will remember the patient we have been discussing to-day was for some time better, but now I doubt if he has been much improved by the operation; nevertheless, post-mortem experience does show that there may be a complete cure. Lastly, it is interesting to note that operation for tubercular peritonitis sometimes benefits tubercle elsewhere in the body. Cases have been recorded in which distinct improvement has taken place in pulmonary tuberculosis after operation for tubercular peritonitis.

Papers by Guy's Men.

Dilatation of the Heart and other manifestations of weakening of the Heart as Results of Rheumatism. By Theodore Fisher, M.D., M.R.C.P. Lond.—*Lancet*, 7th June.

Presidential Address on the Annual Variation of Puerperal Fever compared with that of some Allied Diseases. By A. L. Galabin, M.D. Cantab., F.R.C.P. Lond.—*Lancet*, 14th June.

Case for Diagnosis.

J. W., aged 35, a worker in a gun-metal factory, was admitted into John ward on the 26th of May, 1902, with "abdominal pain and rigidity." He is a married man, his wife is living and healthy, and he has eight children, all healthy and strong. He describes himself as a strong healthy man, save for "dyspepsia and the bringing up of wind." He had never had hæmatemesis, but for the last three weeks has suffered from sickness.

The present illness began at 1 a.m. on the 26th May, 1902. He woke up with severe pain in the abdomen, which persisted. He had hot flannels placed on the lower part of abdomen, but with very little relief. He took nothing by the mouth after the onset of pain, but was sick twice. He was seen by a medical man, who diagnosed "acute peritonitis," and sent him up to the hospital. He was admitted at 11.30 a.m., ten and a half hours from the onset of the acute trouble. His bowels were last opened on the morning of the 25th.

Condition on admission.—Pulse 88, temperature 98°, respirations 24. Patient is a well-nourished, well-built man, with a very sallow complexion. He is evidently suffering a lot of abdominal pain, his knees are bent up, thighs flexed on abdomen, and he gives a grunting noise with each expiration. The tongue is moist and coated with a brown fur. There is no blue line on the gums.

The abdomen moves very little indeed with respiration, but it can just be said to move. On palpation, the abdominal wall is kept very rigid, especially the recti muscles. There is great tenderness on pressure, more especially to left of umbilicus, where also he complained of the greatest amount of pain. Liver dulness normal, not extending below costal margin. The pain in the abdomen is described as cutting. Bladder not distended.

Rectal examination.—Empty. Nothing abnormal.

Vascular system.—Pulse regular, of good tension. No thickening of artery. Cardiac impulse not seen or felt. Sounds best heard in fifth space about nipple line. Sounds normal.

Respiratory system.—Normal.

Urine.—1035, neutral. No albumen. Some phosphates on heating. No sugar.

Nervous system.—Knee-jerks normal. No ankle clonus. Flexor plantar reflex. Pupils react to light and to accommodation.

(For Solution see p. 268.)

Dental Prizes.

The following Prizes have been awarded as under:—

SECOND YEAR'S STUDENTS.—Mr. H. P. Aubrey, Prize £15; Mr. J. G. Morrell, Certificate.

FIRST YEAR'S STUDENTS.—Mr. A. L. Mason, Prize £10; Mr. F. W. Parfitt, Certificate.

PRACTICAL DENTISTRY.—Mr. H. Croot, Prize £10; Mr. H. P. Aubrey, Certificate.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial.

SIR,—May I ask leave to make my little suggestion for the South African Memorial? Certainly the monument should go to adorn the remains of the Park. There is but little open ground left; let us make it as beautiful as possible.

As regards the shape and form of the monument, I would suggest a simple marble pillar, modelled after one of those in the front of Guy's, surmounted by a bronze flag-staff with a bronze Geneva cross flag flying half-mast, the whole surmounted on a triangular granite rocky mass, bearing on its three sides three marble shields—one bearing the arms of Guy's, another the names of the fallen, and the third the dates and name of the war. At the three angles of the base have three bronze representations of large projectiles.

I also think it would be a good plan to keep some of the money, if possible, in hand, in order to keep the memorial in good repair.

Please find my second small donation enclosed.—Yours very sincerely,

GERALD SICHEL.

Royal Naval Hospital,
Haslar, Gosport.

DEAR SIR,—I beg to enclose 10s. 6d. as a subscription towards the South African Memorial Fund, and regret that it should be so late.

I consider the suggestion of "O. L." excellent.—I am, yours faithfully,

GERALD SCHOFIELD.

Bloxham, Oxon.
June 9th, 1902.

Degrees for Conjoint Men.

SIR.—As an old St. Thomas's man, which is next door to a Guy's man, and a reader of your GAZETTE, I venture to ask for information as to your notice concerning degrees and the Royal Colleges, and to make a few suggestions.

Are the delegates mentioned authorised by the Royal Colleges, and acting under their authority? If so, it is evident that the Colleges are beginning to feel the competition of multiplied University qualifications. It is certainly unfair that their graduates should be spoken of as "mere licentiates," and their diplomas discounted in value.

It appears impossible in our country to attain a one-portal system, with University degrees as distinctions

only, but there seems to be a way of bringing degrees and diplomas into line with the minimum of injustice. I would suggest that the Colleges should assimilate their titles to degrees, it being understood that in all formal uses of the titles the source of origin should be stated.

The prestige of a title would thus rest on the University or College which conferred it. The L.R.C.P. would carry the M.B. of the College, the M.R.C.P. the Doctorate of the College. The M. or L.R.C.S. would carry the B.S., the F.R.C.S. the M.S., the courtesy title of Dr. becoming general, as it practically is already.

American Colleges of Medicine all grant diplomas in the degree form. If there be an objection to dropping the time-honoured letters, it would be sufficient to state that they carried the equivalent degree of the College in question. If the Halls could be amalgamated to the Colleges, the matter would be further simplified.

The comparison of sources of qualifications would remain, and possibly it would be better so, but all invidious distinctions would be removed, and the vexed question of "the title of doctor" would sink into well-merited oblivion.—I am, sir, yours obediently,

J. B. PIKE.

The Island House,
Loughborough,
May 25th, 1902.

Great Walking Match in Germany.

DEAR SIR,—This race from Dresden to Berlin, one hundred and twenty-five miles, took place on 18th May, 1902. It derives special importance from the fact that it was promoted by the German Government, though nominally under the auspices of the Komet Sport Club, Berlin. The military authorities there take a keen interest in what would be likely to improve the physique of the Army; and we in England have read lately of the long marches of our soldiers in Africa have had to endure. It was to be test of the staying powers of vegetarians against meat eaters. Four years ago a race of seventy miles was contested in which six vegetarians came in first. A more severe test was now to be applied. The favourites were Mr. Karl Mann, of Berlin, age twenty-eight, who won the race in 1898 in fourteen hours eleven minutes, a German record; and Herr Boege, who had never hitherto been eclipsed. These two had to submit themselves for eleven days to an exact dietary trial. Their respiration, pulse, heart and lungs, and the condition of their nerves were tested by the State-appointed doctors.

The race excited great national interest. The weather was most unfavourable. Thunder, lightning and hail helped to cut short the hopes of many of the aspirants for athletic distinction. Among these Herr Boege retired at thirty miles. He could not compete with the enormous pace of Karl Mann. At forty-seven miles the competitors had to sign their names. There were then five vegetarians first—one of these was G. H. Allen of Leicester. He had recently walked one hundred miles in England with but slight inconvenience, but the want of training and the bad weather beat him after walking ninety miles in eighteen hours.

The second best of the flesh-eaters was Schmidt, who kept up the pace for eleven miles, but arrived eighth after thirty-five hours five minutes. At fifty kilometres (thirty-one and a quarter miles) Karl Mann broke the world's amateur record, covering that distance in four hours fifty-eight minutes. This distance was once before covered in five hours two minutes thirty-six seconds by Mr. A. W. Sinclair, of London, at Lillie Bridge, on 14th November, 1879. Mann also went forty-seven miles in seven hours, and at one hundred kilometres he beat the German and North American record.

The following is the list of the times of the men who finished:—

			Hours.	Mins.
1.	Karl Mann ...	Berlin ...	26	52
2.	Hermann Zerndt ...	Brunn ...	28	58
3.	Martin Reham ...	Berlin ...	30	29
4.	Affar D. Heur ...	Berlin ...	30	57
5.	Thuk	Chemink ...	32	46
6.	Poekfoi	Erfürt ...	34	9
7.	Runge	Berlin ...	34	32
8.	Schmidt	Berlin ...	35	5
9.	G. Gahde	Reudsburg...	39	58
10.	Biber	Berlin ...	41	55
11.	Peterföhn	Berlin ...	44	6
12.	Delees	Efberfeld ...	44	53
13.	Max	Berlin ...	44	58

Of these, the first six, also the ninth, tenth, eleventh and twelfth, are vegetarians; the seventh, eighth and thirteenth are meat eaters. Reham is a life vegetarian, and twenty years of age. The veteran of the race was Gahde, sixty years of age, thirty-eight years of which he has lived on vegetarian diet.

Of Karl Mann, it will interest the public to know that he lives upon purely vegetarian food, discarding all animal products such as eggs, milk and butter. He drinks neither tea, coffee nor cocoa, but only water and the pure juice of the grape. His training consists of his ordinary walks, for, in a letter to a friend, he writes "Quickly walking fifty to seventy miles in the record time of four years ago, if accompanied by a cheerful friend, is a real pleasure to me."—Yours, etc.,

2, Princes Avenue,
Muswell Hill.

C. P. NEWCOMBE.

Pass List.

University of Cambridge.

EXAMINATION FOR THE DEGREE OF DOCTOR OF MEDICINE.

H. A. Gaitskell. W. J. Lindsay.

Types of Medical Students.

THE BACTERIOLOGIST.

As I entered his room I was met with a strong smell of oil, which I ascertained was emitted by a small lamp under what I took to be a new style of coal-scuttle, but which he assured me with pride was a patent incubator of his own invention. The lamp, he owned, was some worry, as it had a habit of going out in the middle of a winter's night and letting the temperature down. Sometimes it blazed maliciously and the germs met the fate of the poor people of St. Pierre. He was immensely proud of it though.

Though still in his fourth year, he had taken up bacteriology with great keenness and rode his hobby at full gallop. Being one of those men who quickly grasp the superficialities of a subject he was master of a bewildering multitude of terms with which it was his delight to bore the ignorant. In fact, these latter used to handle him rather roughly at times in consequence.

In appearance he was like most young scientists. An air of untidiness, brown boots and a black-tail coat, a towzled head of hair, together with dirty shirt cuffs, and a few chemical stains on his waistcoat showed the true devotee of science, superior to this world's conventionalities. I used to wonder on which side he parted his hair, but I eventually concluded he did not part it at all.

"Why don't you get your hair cut, old man?" I said cheerily, for I knew him pretty well.

"Can't, just yet," was the answer, "my brother's out of town."

"Is your brother a barber?" I asked.

"No, you fool," he said, rather shortly. "But you don't suppose I let my hair be cut at one of those dirty shops? I always use my own sterilised scissors and comb, and so have to have it done at home. I live with my brother, you know."

"Well," I began, "I know a very decent place on the Approach, where they do you cheap if you are a Guy's man——"

"My dear sir," he said, turning to me with that light in his eye which told me that I had started him off on his pet theme, "I once took some cultivations from a comb there, and besides many of the ordinary forms of organisms, I isolated a short, rod-shaped bacillus absolutely pathogenic for white mice!"

"Good heavens!" I said, and added musingly, "If it would kill some other white animals that are found in the hair it would make that comb rather useful."

He hates being "got at," so he made no reply, but lit a cigarette which he had just rolled. Like all true bacteriologists he smoked cigarettes. I believe there is only one case recorded of a bacteriologist who smoked a pipe, and the others said his results were not reliable. They have been known to smoke cigars after big dinners, but perhaps that is the result of alcohol. They always make their own cigarettes, too, they never smoke ready-made ones, unless they can get them for nothing. My friend had the characteristic stains on the first two fingers of his left hand, which seem to show more readily on the skin of bacteriologists than on other mortals. He also revealed his calling when he put down a cigarette. Most people put the lighted end free of the edge of the table or mantelpiece. Not so the bacteriologist. He knows the unseen danger lurking there. He puts the lighted end on the furniture, and the mouth end touches nothing. He thus achieves a double purpose; he prevents contamination reaching his lips and destroys any unfortunate germ on which the burning ash is placed. He also ruins your best imitation old oak furniture, but he does not mind that.

"Poor old Dealy," he said presently, "he came an awful cropper the other day."

"Did he?" I asked. I liked Dealy, and knew he used to bet a bit at one time, and I had also been introduced to three different girls to whom he was engaged at various times, so I thought his downfall might be due to one of those weaknesses.

"Yes, you know his dog scratched him in play some time ago, and it caused a rather curious-looking sore; so Dealy, who goes in for bacteriology now, took some cultures from the beast's dew-claw. He worked 'em out, and eventually got a pure growth of an undescribed

diplococcus, when something went wrong with the growths. I looked him up yesterday, and found him awfully sick. I never saw him so down on his luck."

"Poor old chap," I said, sympathetically, and concluded Dealy was ill.

"What do you think he'd done?" he asked. "Why, forgot to filter his agar!"

"Not really?" I said. "What's he got then, typhoid, or something of that sort?"

"Typhoid? No! Why should he get that?"

"Well," I said, "as you said he had not filtered his agar, I supposed he'd swallowed some germs when he drank it."

He gave a gasp and shouted, "My good sir, agar's not a drink, it's a medium!"

"Oh! is it?" I said, and seeing that I had made an ass of myself, I added, "I did not know that Dealy dabbled in spiritualism."

He turned to his microscope with a look of disgust, and I slipped out of the room; and he does not know yet whether I was pulling his leg all the time or not.

The Hereafter.

LESS than a decade has passed since I heard the denizens of the smoking-room lament, between the slices of hot-buttered, that they were compelled to enquire too closely into the intricacies of diseases which would never be seen in the great "private" hereafter. On high authority, I hear that that plaint is never heard now. This attitude of mind, now extinct, recalls the amateur actor, who excuses his present slackness and incompetence with the well-known formula, "It will be all right on *the* night." It will not be. Exploded is the comfortable idea of kind old ladies seeking our services (at high figures) to conduct them softly down the genteel path that leads to the gap beneath the yew, fortified by our smooth, caressing voice and hand, and nicely attuned variations on the lyre, whose strings are bromide, soda, mint, and spirits of chloroform. Oh! twice blessed bromide—"it blesses him that gives, and him that takes"—and is indubitably "mightiest in our mightiest" (patients). Let us erect an obelisk to the great god Bromos, and wreath it about with immortal peacock feathers. Exploded, too, is the hope of a continuous stream of neuropaths, women and half-baked men, clinging, confiding and generous, to our consoling rooms.

The facts are hard and unpleasant. The folk want to be cured, and quickly, too; and there are many ready to do it for them. A short epitome of my first three months as a "squatter," in a small country town may, I think, perform the office of the tin can to the dog, and extinguish the plea of the "browser." My first case—how I yearned over it—was a woman, the wife of a good tradesman, suffering from a severe attack of obstructive gall-stone colic. I suggested cholecystotomy, as I could feel the stones, with itching fingers. She, not unwisely, refused. The next, a difficult case of meningitis—difficult, because parents must know "all about it" since the Board School ruled the land, and prognosis is the—Lyceum—as one of my teachers taught us in "those days." Then a lad with deafness, due to Eustachian obstruction, which required the inflation frequently of his middle ears, through catheters, and when he was screwed up to it, curetting of the post nasal space. Why did I worry? Motives mixed! My rivals had given him up as hopeless, and there may be "a little fee attached" in the coming bye-and-by. Moreover, it makes one, like Topsy, "feel good" to present a man again with a large slice of a lost sense. The son of a rich farmer had been treated for asthma, and then for phthisis. He was a bright, rosy-looking yeoman, lately returned from the war. He stated that he had lost a stone and a-half in weight. It seemed absurd; but I was moved to take his temperature (102° F.). I stripped him, and found a large pleuritic effusion on the right chest. He would not be tapped; he'd be d—d if he would. Time, fresh air, and extensive exercise have removed the fluid, the asthma, and the phthisis. His mother fell ill with a diffuse purpuric rash. Small-pox was near at hand. Was it variola? "I tell you, sir, it takes nerve and knowledge to do the right thing," as the steeplechaser said. A farmer from a distant village came with a sore on his lip. His own doctor "would not tackle it." That village hung on his lips. I sliced it out with the submental glands, and sent him to walk round that village on the sixth day, without a dressing.

Then three more adenoid operations came my way. Next a "pretty lad" of twenty, son of the lady of the gall-stone, came, with a trivial swelling of his ankle. Father looked dubious when I suggested that it was serious. A month later, he hobbled in to me in great pain. I stripped the lad, and found a fibroid phthisis, or some allied condition. Next step, "extension" for nocturnal starting pains, followed by a Croft splint. You want all the ingenuity and practice you can lay your hands on in hospital to make it possible to do these things with clumsy country help.

A pale, weedy youth has suffered much at the hands of many physicians during the last five years for chronic dyspepsia. On my new couch (constructed with my own hands), I waylaid his dilated stomach, washed it out a few times, corrected his hypermetropic astigmatism, and now the other physicians take a back row. Then came a severe Grave's disease, with no less than nine D of myopia uncorrected; a case of Raynaud's disease, in a clock maker; a father, with tracheal obstruction, due to pressure of a large thyroid, which had been referred to laryngitis and asthma; his daughter, with a tremendous bunch of nasal polypi. The "hated rival" had

pulled off "little bits" with shaking hands and forceps. It was do or die! I cut five with the snare at the first sitting, and six at the next. There are others waiting.

I could add a few more cases. Alas! only a few; but enough, perchance too much, has been said to emphasise the imperative necessity of knowing and doing more than the "other fellow," if you are to succeed in the competition. The "other fellow" is becoming continually more cute; it is harder to outstrip him; but "dogged will do it." The essentials are that you should have a broad clinical basis to work on, see every patient that you can get near; talk to him, learn to manage him *suaviter in modo fortiter in re*. Do a course of ears, eyes, throats and gynæcology. It takes time and energy. No need to be an expert; but acquire a sound working knowledge. The race is to the swift. Moreover, you will discover, as a physician said to me, after he had skilfully steered the mother of a family through a desperate illness, "It is sometimes worth while to be a doctor."

"SPERO."

Nursing News.

MATRON'S OFFICE.

On May 12th Sister Edith (Miss Lewis), Medical Night Sister, was transferred to the Out-Patient Department, and Miss Ada Fricker, who entered the Hospital as a Probationer in 1891, was appointed to succeed her as temporary Medical Night Sister. On leaving the Hospital in 1895, Miss Fricker joined the Staff of the Private Nursing Institution, which she left in September last, having been appointed Lecturer on Nursing to the Devon County Council.

Sister Stephen (Miss Creighton) left the Hospital on May 26th, and Mrs. Strathern returned to take charge of Stephen.

Mrs. Lyon, who received her training as a Lady Pupil in 1896–7, returned to the Hospital on the 14th inst. to take Sisters' holidays.

Miss Gertrude Morrah, who completed her training as a Probationer last year, has been appointed holiday Sister.

Nurse Lowe left the Hospital on May 21st, on completion of her three years' training, and Probationer Chittock was appointed to succeed her as Head Nurse in Dorcas Ward.

Probationer Walker was appointed on the 5th inst. to succeed Nurse Gibbins as Head Nurse in John Ward.

Nurse A. Davis, Head Nurse in Bright Ward, left the Hospital on the 17th inst., on completion of her three years' training.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. F. C. Wetherell, C. H. Robertson, H. A. Cutler, N. N. A. Houghton, C. J. Pinching, H. Barber.

Clinical Assistant in Medical Out-Patients.—Mr. P. W. Hamond (Dr. Bryant).

Obstetric Dressers.—Messrs. E. W. Strange, B. H. Wedd, J. H. Donnell (1st half); C. F. Fraser (2nd half).

Dressers in the Throat Department.—Messrs. E. Faulks, A. W. Iredell, H. Tipping, H. S. Brown, L. H. Moiser, O. W. Richards.

Assistant Surgeons' Dressers.—Messrs. P. P. Cole, H. H. Carter, L. H. Frankenberg, E. Lloyd (Mr. Lane); A. M. Webber, M. G. Louisson, H. F. Bell Walker, O. V. Payne, G. A. Ticehurst (Mr. Dunn); A. E. F. Kynaston, G. H. Rees, B. Moiser, B. H. Stewart (Mr. Fripp); J. F. Rey, R. P. Rowlands, F. Alcock, R. A. Greeves (Mr. Steward).

Medical Ward Clerks—Messrs. G. Nunn, F. Rogerson, R. St. G. Seagrove, R. D. Bridger, W. S. Orton, R. M. Rendall, C. Dismorr, H. H. Jenkins, A. V. Maybury, M. J. Mottram, G. C. F. Robinson, J. D. Thomas, A. F. Hertz, E. C. Myott, F. W. Morton Palmer, F. Barnes, J. H. Clatworthy, A. M. Roome, G. Russell, J. H. Barrionuevo, A. M. Benett, G. H. Cheyney, D. Isaacs, J. McF. Pollard, J. E. Prentis, W. Reeve, H. D. Wyatt, W. N. May, E. W. Routley, W. M. Mollison, L. J. J. Orpen, C. P. Harvey.

Surgical Ward Clerks.—Messrs. L. Doudney, R. Felton, A. Leeming, J. O. Musson, J. Cook, P. F. Minett, L. Myer, E. C. Peers, P. A. S. Dyson, A. S. Littlejohns, S. M. Wells, E. C. Hughes, C. M. Stevenson, H. M. Clarke, E. W. Sheaf.

Clerk in the Skin Department.—Mr. E. G. Goldie.

Aural Surgeon's Dressers.—Messrs. W. C. Lewis, F. H. Parker.

South African Memorial Fund.

TWELFTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	222	7	6
F. W. A. Bryden	1	1	0
V. A. Jaynes	1	1	0
Gerald Sichel, F.R.C.S. (2nd donation) ...	1	0	0
R. D. Attwood	0	10	6
F. W. Cock, M.D.	0	10	6
J. J. Nason, M.B.	0	10	6
J. A. Reaside	0	10	6
F. W. Rowland, M.B.	0	10	6
Gerald Schofield, M.D.	0	10	6
F. W. Ta'Bois	0	10	6
"Heathen"	0	10	0
C. R. A. Sutton, M.D.	0	10	0
T. B. Luscombe	0	5	0
David Thomson	0	5	0
	£230	13	0

Passim.

For the last week and more a gloom has been cast over the Hospital as it was known that Dr. Washbourn lay at death's door, and that no hopes were entertained of his recovery. It is our sad duty to record that he died early yesterday morning. About three months ago he had a severe attack of influenza, since when he has been continuously ill. The influenza was followed by pleurisy with effusion, and it was only after paracentesis had been performed on two or three occasions, and his temperature shewed no signs of falling, that the serious nature of his illness was generally known. Three weeks ago it was deemed advisable to try a change of air, and he was moved to Tunbridge Wells. The fear which had been entertained that he was suffering from general tuberculosis was only too fully realized, and for the past few days he has been steadily sinking. With Dr. Washbourn, Guy's loses one of her most distinguished physicians, a thorough sportsman, and a courteous gentleman, beloved by all of us.

The meeting concerning the South African Memorial took place on Tuesday, June 17th, and although little actual business was got through, the time occupied was well over an hour. Dr. Taylor took the chair, a goodly number being present, most of whom put forward amendments at some stage or other of the proceedings. The Chairman introduced the subject and made a statement concerning the actual amount collected, about £230, with which it was proposed to honour the eleven Guy's men who have fallen in South Africa. The first proposal that was put forward was to erect a bronze tablet indoors, preferably in the Wills' Library, and met with a fair amount of support, but the party in favour of an outdoor memorial were in a large majority, as were most of the subscribers who had recorded their opinions. No actual designs were put forward except the one sent to us by Mr. Gerald Sichel.

As no definite conclusion could be arrived at it was decided to elect a Committee, to which Mr. Hodgson, in a carefully worded resolution in his best legal language, would have given absolute control. Dr. Taylor, having corrected the proposer's composition, put it to the meeting, but the company would have none of it, and emphatically declared that, should the Committee be unable to execute an outdoor scheme the whole matter should be referred to another general meeting. A slight wrangle occurred over the question as to what was meant by an open space or outside wall, which was at length overcome satisfactorily. The meeting agreed that the Committee of the Gazette should have the power to act, and added to that body Dr. Gibson, of Aldershot, and Messrs. Brailey and Cross, so that some definite conclusion should shortly be arrived at. It was further agreed that the sum that has been spent by the Gazette in printing and posting the circular-letter to old Guy's men should be refunded if desired.

As already stated, the balance of opinion was decidedly in favour of an outdoor memorial, and apparently the Colonnade was considered to be the most suitable place. The several proposals for monuments to stand in various places did not meet with much approval, as it was felt that with the sum available nothing sufficiently imposing and artistic could be erected. Dr. Gibson came forward with several ideas, supported by details as to cost and other such necessary information, and his election on the committee was most fortunate.

From the last number of the *Lancet* we see that trouble has once more arisen in court concerning the payment of a medical witness's fees. The demand for the payment of his fee

before giving evidence, brought upon the doctor some harsh comments from the judge on the circuit. The old and threadbare tale of the poverty of the plaintiff was put forward, and his inability to pay the usual fee of one guinea was held out in a reproachful way. The plaintiff no doubt had enough funds to enable him to test his case, which is no matter for the penniless, and the doctor naturally objected to being the only unpaid professional man doing duty in court. It is absurd to expect a medical man to be philanthropic in a law court. The help of a solicitor is not forthcoming to one who pleads poverty in such a case, and why, then, should one of our own profession, who has possibly to pay another to do his work, be expected to give the evidence which is absolutely necessary, and be blamed when he asks for payment?

No doubt it looks better to receive a fee after earning it, but solicitors engaged in cases in which medical men are called frequently as witnesses — viz., those of compensation for injury—are by no means all souls of honour, and many are the men who have been disappointed of their fee, trusting to the promise of payment after evidence has been given. Anyone who has held a house appointment here knows the truth of this, and once having been bitten in this way, a man is not likely to study appearances when the payment of his fee is only a matter of promise. These cases are, for the most part, attempts at extortion, and are run on business lines of the sharpest order, and therefore we say that no medical man should give evidence without previous payment of his fee unless the firm of solicitors which promises his fee are personally known to him.

FROM the daily papers we see that Pat Manson was buried in the Happy Valley, at Hong Kong, on May 5th, and that his funeral was attended by all the prominent residents of the island, where he was born.

THE Goblins' Club (Guy's men of the 1891 and 1892 entries) held their annual meeting and dinner at the Café Royal on May 28th. The gathering, under the presidency of Dr. F. J. Nicholls, was a most successful one, a little more than a fourth of the total number of members being present—a very satisfactory result considering the fact that so many members are abroad in various parts of the world. The president for the ensuing year is Mr. E. F. Clowes, Mr. L. E. C. Handson follows Mr. K. B. Alexander as *vice*, and Mr. Henry continues as secretary. As the club had a good balance in hand, it was unanimously resolved to send five guineas to the South African Memorial Fund.

THE Cricket team, though not so strong as last year's team who brought the Cup back after several years' absence from our smoke-room, ought to have made a better fight to keep it than they did last week. It has not been a good season to get a team into its best form, but we can at any rate say that our failure was not due to a want of enthusiasm. It is probably sufficient to admit our disappointment and say no more about it; it is not of much avail to try and find excuses, or account for a somewhat unexpected defeat. It has been attributed to overconfidence and also to nervousness; there may be some truth in both of these, the fact remains, however, that every cricket team has its days when nothing will go right, and this was certainly one of our unlucky days.

THE Sports were held on Wednesday last, and proved a great success. The great essential to meetings of this sort, good weather, was fortunately with us, and tempted by it, quite a large crowd assembled at Honor Oak Park. Beside being a success as a social function, the events shewed that we should have a good team to represent us on Wednesday next at Stamford Bridge, in the United Hospital Sports, and that our chances for regaining the Athletic Shield, which has been too long absent, are not to be despised. Unfortunately, one or two of our men, on whom we rest our hopes, are not fully in form, owing to illness, but we hope that the day may find them fit enough to show their true merit.

It is a matter of regret that the fresco in the present nurses' dining-hall, by Mr. Draper, cannot be removed, but many will learn with delight that the new dining-hall in the Henriette Raphael Home will be beautified by the gift of Mr. Herbert Raphael. The design of Miss Chaplin, which won the Academy prize of the present year for decorative painting, will be executed on a gigantic canvas extending across the whole width of the room at his expense.

The arrangements for the opening of the Henrietta Raphael Nurses' Home by T.R.H. The Prince and Princess of Wales, on July 7th, proceed apace. The formal ceremony will take place in a large pavilion to be erected in the park, with the Home itself as a background. This pavilion is to be of the utmost size which the circumstances will permit of, but even then it will only accommodate a proportion of the guests. In the allotment of seats, the hospital authorities may be trusted to act equitably, and the route by which the Prince and Princess will proceed to and leave the Home, has been so arranged as to bring T.R.H. in good view of the whole company, which is already assured will be distinguished and numerous.

As a mark of respect to His Royal Highness, the President, the Staff have determined to wear academic costume on the occasion, and it is hoped that as many present and past Guy's men as possible will follow this example. Arrangements have been made with Messrs. Ede & Son, as in former years, for the supply of gowns, hoods, and caps, to such as may desire them. Post-cards addressed to Messrs. Ede & Son, on which requirements may be stated, can be obtained in the office of the Secretary to the Treasurer.

We are asked to state that in order to facilitate the arrangements, everyone desiring to be present on the day, whether a Governor, Member of the Staff, or a Student, is expected to be the holder of a card of admission. There will also be issued a second card for any friend whose name is supplied. Applications should be made to the Secretary to the Treasurer. If, later on, it be found possible to issue additional invitations to friends of students, notice will be posted.

The Guy's Biennial Dinner will take place on Tuesday, July 1st, at the Hotel Metropole, at 6.30 p.m. Dr. Galabin in the chair. Tickets, price one guinea, inclusive of wine, may be obtained of the Hon. Sec., Dr. Pitt. It is hoped that those intending to be present will apply early for tickets, so that arrangements can be made in sufficient time.

We are sorry to say we cannot give our correspondent any further information concerning the giving of degrees by the Royal Colleges than the notice published in our issue of May 24th. Presumably the Charter would have to be reconstructed to make such a thing possible, and the scheme is not sufficiently supported to warrant such a step being thought of.

As we are going to press we learn that Guy's were defeated by St. Bart's. in the final round of the Water Polo Cup, by three goals to two.

The Dental Society.

The Annual General Meeting of the Dental Society was held on Friday, May 30th, the President, Mr. Ernest B. Dowsett, occupying the chair.

The minutes of the previous meeting having been read and confirmed, the Chairman announced that the Society's prize had been awarded to Mr. G. A. Donald, for his paper on "Erosion."

The Hon. Secretary and Treasurer then presented the annual report and balance sheet, both of which were unanimously adopted.

The officers for the ensuing session were then elected, the balloting resulting as follows:—President: P. S. Campkin, Esq. Vice-Presidents: M. F. Hopson, Esq, J. Lewin Payne, Esq., E. B. Dowsett, Esq., R. P. Rowlands, Esq. Hon. Sec. and Treasurer: A. D. Crofts. Committee: Messrs. J. E. Spiller, H. P. Aubrey, H. E. Collett, S. A. Piper, and H. J. Snowden.

The Chairman then gave a short valedictory address, in which he alluded to the marked success of the past session. He concluded by wishing the new officers a prosperous year.

A vote of thanks to the retiring President, proposed by Mr. P. S. Campkin and seconded by Mr. H. C. Visick, terminated the proceedings.

In the Medical Wards.

Hannah S., æt. 42, was admitted into Clinical in a comatose condition. Eight years before she was an in-patient at St. Thomas's Hospital, where she was treated for diabetes mellitus. Her family history was interesting, in that her nephew had died of diabetes, and the patient in her only pregnancy had developed exophthalmic goître.

During the last eight years she had roughly dieted herself, so that until five months age she could perform the ordinary household work, but in February last she grew very drowsy and had to lie up for a time. From that time she has had transient attacks of drowsiness and has lost weight rapidly.

On admission.—The patient, a small, dark, thin woman, was distinctly comatose. She had marked "air-hunger," with a gasping respiration of 32. Her breath was very sweet, so that the corner of the ward in which she lay smelt strongly of acetone. For the last few days the woman had vomited and complained of pain in the abdomen, chiefly along the attachment of the diaphragm. The bowels were confined. She had persistently refused to go to a doctor, and it was only when she became quite comatose that her friends could bring her to Guy's. There was no cyanosis, the absence of which, with such marked respiratory distress, was, Dr. Hale White said, sufficient to enable one to diagnose diabetic coma. The tongue was large, dry and beefy. No knee-jerks could be obtained. The urine was very acid and contained albumen and seven grains of sugar to the ounce. A marked ferric chloride reaction was present.

Immediately on admission the bowels were opened with an enema and 180 grains of sodium bicarbonate in solution were infused into the right breast. 100 grains of sodium bicarbonate were also given per rectum and oxygen inhalations administered.

This was at 12 noon. The effect of the alkali was most marked. The woman soon became more conscious and mumbled for something to drink. At 6 p.m. she managed to get out of bed and wandered out of the ward in search of drink. That evening the coma gradually returned. She was given 100 grains of sodium bicarbonate per rectum and three drachms by the mouth every four hours. During the night she was semi-comatose but was more conscious again the next morning. There were several attacks of heart failure which readily responded to strychnine and digitalis.

In the afternoon of the second day the coma gradually deepened, and in spite of a second alkaline infusion into the breast the woman died at 6 p.m.

At the post-mortem, there was evidence of chronic nephritis. The pancreas was rather cirrhotic. The sugar dropped from 7 to 3 grains per ounce during the two days the woman lived in hospital. No attempt was made to diet her.

In spite of the large doses of sodium bicarbonate given the urine never became alkaline. The urine contained a large quantity of Boxy-butyric acid which gave a good yield of crotonic acid.

The chief interest of the case lay in the way in which the woman reacted to the sodium bicarbonate in the early stage. From a condition of complete coma she recovered sufficiently to walk out of the ward.

Ethel C., æt. 12, was admitted into Miriam for a tumour of the chest and abdomen. Six months ago she first complained of pain in the right side of the chest and shoulder, of a dull aching character. The tumour grew slowly at first, but during the last few weeks it has increased rapidly in size.

On admission.—The right side of the chest was pushed outwards and forwards. The tenth, eleventh and twelfth ribs were especially prominent. The abdomen was very full and bulged in its upper part, especially on the right side, the most prominent part lying below the costal margin towards the mid-line.

The abdomen was quite supple and moved well with respiration. On palpation, a uniformly hard, smooth tumour was felt, reaching down almost exactly to the umbilicus on the right side. When traced across the abdomen, it ascended rapidly towards the left costal zone, where it disappeared. A notch could be felt corresponding to the notch of the liver. The spleen could be felt, very hard and much enlarged as an independent mass. The tumour was everywhere dull, and yielded a thrill from behind forwards. The right lung was distinctly compressed. No enlarged glands were felt.

The mass was diagnosed as an enlarged liver, due either to sarcoma or hydatid disease. Dr. Hale White excluded sarcoma on the ground that the child was too fit for such a long history. She had always lived in London except for a few months about six years ago, when the family lived on a farm in Norfolk. Hydatid disease of the liver was diagnosed, and Mr. Dunn was asked to operate.

At the operation.—An incision was made just below the costal margin, at the most prominent part of the tumour. The liver was exposed and looked quite healthy. An exploring needle was then thrust in, when clear watery fluid came away. The liver was stitched to the abdominal wall around the opening, and after a large quantity of fluid had drained away, a small trocar and cannula were employed to empty the cyst. Four pints of fluid were withdrawn. The cyst was lined with a pale white friable membrane, containing gelatinous matter. This, the endocyst, was all pulled away, and the cavity drained. The fluid obtained did not coagulate, contained no albumen, but was full of hooklets and scolices. Specific gravity 1010. Lately the fluid draining away has been bile-stained. The cyst for the last fortnight has been discharging about four ounces of fluid per diem.

Reviews.

The price of books submitted for review should in every case be stated.

The Operations of Surgery. By W. H. A. Jacobson and F. J. Steward. Fourth edition (J. & A. Churchill), 2 vols. Price, 42s.

The fourth edition of this work has been expected for a considerable time, and its appearance fully justifies the interest in its production. Although a laudable endeavour was made in former editions to keep the size of the book as small as possible, the incorporation of accounts of new methods and advances in surgery has necessitated the publication of two volumes instead of one. A text-book in surgery is better for good pruning of intricate detail but in a book of reference, such as this is intended to be, the various methods and details of operating cannot be too fully described and therefore we think that the enlargement of the work is not so much to be dreaded as the preface to the previous editions would have us believe. The plan of dividing the subject into descriptions of operations on various regions is adhered to, and we think rightly, as it is more likely to be read with anatomy, and leads to less confusion than any other scheme.

Naturally the accounts of amputations and many other procedures have undergone little or no change where there has been little advancement made in our knowledge, but there are considerable alterations made in keeping with recent improvements.

In the first volume there is an excellent account of tendon grafting which, however, we think might be considerably improved by the addition of diagrams, as any description is likely to prove difficult reading. The same improvement, we think, might with advantage be made in several other of the divisions, as such a good series of illustrations as there are in the section on hernia, and on removal of the breast and its lymphatics and mastoid operations are of inestimable value. Mastoid antrectomy naturally occupies a prominent place, and the accounts of the latter-day methods are in keeping with the illustrations. Another section which is noteworthy on both of these scores is that on plastic operations on the lips and palate.

Malignant disease, of course, receives much attention and happily much instruction is given on other points than pure treatment. Again and again our notice is attracted to the test of time and warning given about too optimistic a prognosis. Perhaps the section on treatment of cancer of the tongue is the best, and although the rules given for treatment do not meet with the approval of all surgeons, they are admirably suited to those whose experience is not of the greatest and for whom the advice is intended, as is insisted on in several places. This is exactly what is required. We do not wish to know how a surgeon of great dexterity would act, but wish to know the best line of treatment for a man of ordinary attainments. Although it is difficult to pick out any particular section for special mention, that on intra-abdominal operations is particularly good, and beside being highly instructive is eminently readable. Appendicitis naturally occupies a large space, and the arguments for and against early operation are well put forward. An aphorism concerning the occurrence of ventral hernia which is advanced as an objection to the surgical treatment of the disease, is particularly apt, viz., "It will be better for such a patient to be fitted with an abdominal belt than to be measured for his coffin." The tendency to use Murphy's button to the exclusion of all other methods of intestinal anastomosis is deprecated.

In conclusion, we must say that the present edition is a worthy successor to the previous ones, and cannot fail to achieve the popularity that the book has always met with.

Manual of Surgical Treatment. By Cheyne and Burghard, Vol. 6. (Longmans Green & Co.) 18s. nett.

The sixth volume of this already popular text-book is fully up to the standard of the other volumes. The original idea of publishing the work in six volumes has had to be abandoned on account of the disfavour with which the authors view the necessary curtailment to accomplish this. It is difficult to see how it might have been condensed without its value as a book of reference as regards treatment being considerably diminished.

Operations on the tongue and pharynx occupy a large portion of the present volume and the text is excellent. The diagrams are numerous and most useful and show a number of incisions that are not made use of in our own hospital. In operations on the neck we notice that the authors advocate flap incisions in place of straight ones which are commonly used.

To our mind the chapters on gastric and intestinal surgery are the most noteworthy on the score of brevity and instructive value.

Rectal feeding is put in a prominent position, and larger enemata, very similar to those which are now given at Guy's are recommended in place of the old-fashion nutrients.

Altogether the volume is a good one and ranks with its fellows as an excellent book for reference.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

From the Gazette's Special Pathologist.

ALL specimens—particularly those of solid tissues—should be accompanied, if possible, by a short clinical and post-mortem history, and a postal order for 2s. 6d. An extra charge of 6d. per slide is made when prepared sections are to be forwarded.

Diphtheria specimens are to be labelled *Immediate*.

Postal Orders to be made payable to Mr. C. H. WELLS.

NOTICES.

J. J. C., BRIDLINGTON.—This gland is tuberculous. It shows a large number of giant-cell systems and is undergoing caseation.

T. R. A., CHADWELL HEATH.—This sputum was mucopurulent in character, and contained numerous putrefactive organisms, but the microscopical examination revealed no tubercle bacilli.

H., RAMSGATE.—A section from this breast tumour shows the characteristic appearance of a schirrus carcinoma. The surrounding fat is infiltrated.

H., REIGATE.—This sputum was slightly purulent, but the tubercle bacillus could not be found in suitably stained films.

PATHOLOGIST.

Sport.

Guy's Hospital Athletic Sports.

The Annual Sports were held at Honor Oak Park on Wednesday, 18th. After a long spell of wet weather, we were fortunate in getting the first really fine day, and consequently there was a large attendance, in fact it was a record gate for this meeting. Although the number of entries was not so big as might be hoped for, some fairly good fields turned out. In the two long distance races some new blood was discovered. Although having a good start in both events, Pilbeam shewed that he was a runner of some merit, and simply romped home. As this is his first year of racing, he should prove a very useful acquisition to the team. Morgan won the 100 yds. easily from scratch in the excellent time of $10\frac{2}{5}$ secs., and was second in the long jump, failing to concede one foot to Plummer, who also won the high jump.

Litchfield did well, carrying off three prizes. Rankine unfortunately was not able to compete in the weight and hammer events, owing to ill-health, but is, we believe, now almost right again.

The donkey race provided much amusement to the spectators, but less to some of the competitors.

Mr. Higgens won the first heat in great style, and was placed in the final, which was won by that well-known horseman, Wall. The tug-of-war was a good event, and was won easily by the crocks.

The veterans' race fell to Roper.

The prizes were distributed by Mrs. Fawcett.

The President, Mr. Clement Lucas, proposed a vote of thanks to Mrs. Fawcett, and trusted that we should have a big crowd of Guy's men at the United Hospital Sports on Wednesday next.

Dr. Fawcett replied, thus concluding one of the most successful meetings in the annals of the Athletic Club.

100 YARDS.

1st Heat.—1. E. Morgan. 2. G. N. Bartlett.
Time, $10\frac{3}{5}$ sec.

J. S. Bookless, F. B. Lowe, J. E. Hodson also ran.

2nd Heat.—1. S. A. Piper. 2. J. E. Monro.
Time, $10\frac{1}{2}$ sec.

S. Reader also ran.

FINAL HEAT.

1. E. Morgan.
2. J. E. Monro.

Time, $10\frac{2}{5}$ sec.

PUTTING THE SHOT.

1. A. Zorab, allowed 3ft.
2. E. M. Harrison, alowed 5ft.

Distance, 30ft. 1in.

HALF-MILE.

1. A. W. Berry, 45 yards.
2. P. C. Litchfield, 20 yards.

Time, 2 min. 5 sec.

R. W. Allen, R. J. Bentley, J. S. Cooper, G. F. Hardy, L. Doudeney, also ran.

120 YARDS HURDLES.

1st Heat.—1. E. M. Harrison, scratch.
2. E. A. Plummer, 8 yards.
Time, $17\frac{3}{5}$ sec.

E. Morgan also ran.

2nd Heat.—1. J. E. Hodson, scratch.
2. S. A. Piper, 10 yards.
Time, 18 sec.

FINAL HEAT.

1. E. M. Harrison.
2. J. E. Hodson.

Time, $17\frac{3}{5}$ sec.

THOWING THE HAMMER.

1. E. M. Harrison, allowed 20ft.
0. J. E. Hodson.
0. S. A. Piper.

Distance, 78ft 2in

ONE MILE.

1. E. L. Pilbeam, 45 yds.
2. O. S. Norton, scratch.

Time, 4 min. 44⅘ sec.

O. B. Travers, S. Wacher, J. S. Cooper, H. T. Hills, also ran.

220 YARDS.

1. P. C. Litchfield, 12 yds.
2. R. W. Allen } Dead heat.
   E. Morgan }
3. J. E. Monro.

Time, 24⅖ sec.

VETERANS' RACE, 150 YARDS.

1. R. S. Roper, 5 yds.
2. M. A. Collins, 2 yds.

Time, 17⅕ sec.

P. W. L. Camps, D. H. Trail, L. G. Nash, also ran.

HIGH JUMP.

1. E. M. Plummer, allowed 2in.
2. J. E. Hodson, scratch.
0. H. A. Watney.
0. J. E. Monro.
0. S. Reader.

Height, 5ft. 3in.

440 YARDS.

1. P. C. Litchfield, 15 yards.
2. H. Wight, 25 yards.

Time 54⅖ secs.

R. W. Allen, J. S. Cooper, also ran.

LONG JUMP.

1. E. N. Plummer, allowed 1ft.
2. E. Morgan, scratch.
0. J. E. Monro.

Distance, 20ft 1in.

THREE MILES.

1. E. L. Pilbeam, 45 secs.
2. O. S. Norton, scratch.

Time, 16 min. 49 secs.

DONKEY RACE.

1st Heat.—1. Mr. Higgens.
2. A. C. Ransford.
3. J. C. Bradbury.

E. Minett, A. M. Tolhurst, F. A. Sharpe, R. S. Roper, A. Zorab, R. B. Dawson, A. F. Denning, W. N. May, also competed.

2nd Heat.—1. M. A. Collins.
2. H. J. Henderson.

G. Wacher, G. Evans, H. T. Palmer, C. P. Harvey, B. B. Metcalfe, J. S. Cooper, R. Willan, E. C. Lowe, also competed.

3rd Heat.—1. A. H. E. Wall.
2. W. H. S. Burney.
3. G. F. Harding.

M. Earle, D. H. Trail, J. E. Hodson, R. Larkin, E. M. Harrison, C. C. Litchfield, P. L. Camps, L. Doudeney, also competed.

FINAL.

1. A. H. E. Wall.
2. Mr. Higgens.
3. W. H. S. Burney.

TUG OF WAR.

CROCKS.—A. E. Wall, D. H. Trail, F. D. S. Jackson, G. Evans, P. W. L. Camps, R. Griffiths *beat* 3RD YEAR.—E. M. Harrison, J. E. Hodson, E. C. Lowe, E. L. Norton, H. S. Knight, H. A. Watney.

4TH YEAR.—R. D. Bridger, R. G. Anderson, A. M. Rendal, A. M. Tolhurst, G. Featherstone, G. Watts *beat* 1ST YEAR.—F. Alcock, M. Earle, E. Minett, J. E. Munro, J. L. Rankine, S. M. Saunders.

2ND YEAR, a bye.

S. M. Watts, M. R. Smith, P. F. McEvedy. F. W. Hogarth.

CROCKS *beat* 2ND YEAR.

FINAL.

CROCKS *beat* 4TH YEAR.

Cricket.

GUY'S v. WANDERERS.

Played at Honor Oak Park on Monday, May 19th, and we were certainly very fortunate in the result—a draw. The Wanderers batted first in cold unsettled weather, Darke and Beldam both playing splendid cricket. Guy's had an hour and forty minutes to bat in on an easy wicket, the first wicket added 46 runs in fifty minutes and afterwards none attempted to stay. What certainly spoilt the match was a certain collective "lackadaisicalness" in the field, five or six easy catches were dropped in the first two hours' play. Scores:—

WANDERERS.

S. Colman, b Wyatt	15
T. A. Darke, c Norton, b Bookless	103
E. A. Beldam, not out	101
E. N. Fisher, c Wyatt, b Bookless	3
A. M. Latham, b Hicks	8
L. E. G. Hadath, b Hicks	3
B. Burton, b Hicks	16
W. J. Bryant, not out	12
Extras	5
Total	266

S. C. Wyatt, O. Taylor and L. E. Stedman did not bat.

GUY'S.

H. D. Wyatt, b Bryant	11
H. Barber, c Hadath, b Taylor	32
F. Morres, b Taylor	10
E. L. Norton, b Stedman	5
S. C. Bowle, c Latham b Taylor	0
E. Morgan, c & b Stedman	20
E. A. Collins, b Taylor	1
H. M. Tolhurst, not out	8
J. T. Hicks, b. Stedman	2
J. Bookless, not out	1
Extras	8
Total	98

M. G. Louisson did not bat.

GUY'S v. LONDON COUNTY C.C.

Played on Wednesday, 28th May, at the Crystal Palace, and ended in a draw. On a perfect wicket the County batted first and Damian and Poidwin added 131 for the third wicket. We started badly but Wyatt with Morres added 86 for third wicket, the latter playing a most careful and useful innings. Scores:—

LONDON COUNTY C.C.

O. J. Damian, not out	159
F. E. Smith, b Foster	1
F. A. B. Anderson, c Louisson, b Bookless	43
L. O. S. Poidwin, b Bookless	79
A. F. Newman, c Norton, b Barber	0
G. Robey, b Barber	1
E. H. Lulham, c Louisson, b Barber	2
A. E. Damian, not out	19
Extras	9
Total	313

Innings declared closed.

D. H. Woolven, H. A. Budden and Ford did not bat.

GUY'S.

H. Barber, c Ford, b Budden	27
H. D. Wyatt, c Damian, b Lulham	77
H. M. Langdale, c Newman, b Budden	1
F. Morres, not out	69
E. L. Norton, c Smith, b Lulham	5
R. Willan, c Damian, b Smith	27
E. A. Collins, c Damian, b Lulham	3
Extras	6
Total	215

G. C. Bowle, J. Bookless, H. L. Foster, and M. G. Louisson did not bat.

GUY'S v. REIGATE.

This victory, coming at the end of three lean weeks, was most gratifying. We were beaten by 3 runs on the first innings, but Reigate were disposed of for 77 in their second innings, mainly owing to some fine bowling by Davies, who in the match secured 9 wickets for 28 runs. Guy's had to make 80 runs in an hour and thirty minutes, and made them in forty minutes, Morgan scoring 55 not out in twenty-five minutes, a brilliant performance without a chance, his hitting being clean and well timed. Scores:—

REIGATE.

1st Innings.		2nd Innings.	
F. J. Nightingale, b Davies	1	F. J. Nightingale, b Morgan	22
H. B. Walters, c Collins, b Wyatt	14	R. W. Neale, c Morgan, b Foster	2
F. T. Nightingale, b Wyatt	10	H. B. Walters, c Willan, b Wyatt	9
F. W. Neale, c Willan, b Davies	13	J. W. Neale, c Collins, b Davies	17
R. W. Neale, c Louisson, b Wyatt	0	F. T. Nightingale, b Davies	11
H. A. Hurley, c Barber, b Davies	4	R. E. Neale, not out	8
H. Mitchell, b Davies	5	H. A. Hurley, c & b Morgan	0
R. E. Neale, c Morgan, b Wyat	0	H. Mitchell, c Barber, b Morgan	0
B. T. Kenward, b Davis	2	—. Brickett, run out	6
F. C. Morrison, b Wyatt	1	B. T. Kenward, b Davies	0
—. Brickett, not out	1	F. C. Morrison, b Davies	0
Extras	10	Extras	2
Total	61	Total	77

GUY'S.

1st Innings.		2nd Innings.	
H. B. Wyatt, c Kenward, b Nightingale	16	H. D. Wyatt, run out	8
H. Barber, lbw, b Brickett	12	H. Barber, not out	20
E. L. Norton, lbw, b Brickett	0	E. Morgan, not out	55
F. Morres, b Brickett	8		
R. Willan, Jr., c Walters, b Brickett	2		
E. Morgan, c Walters, b Morrison	1		
E. A. Collins, b Morrison	5		
A. L. Foster, c Neale, b Morrison	0		
J. Bookless, not out	7		
L. G. Davies, c & b Morrison	1		
M. G. Louisson, c Nightingale, b Morrison	6		
Extras	1		
Total	59	Total	83

E. Morres, A. L. Foster, R. Willan, E. L. Norton, E. A. Collins, J. Bookless, L. G. Davies, M. G. Louisson, did not bat.

GUY'S v. R.I.E.C.

Played at Cooper's Hill, on Saturday, June 7th. Our opponents had lost one wicket for 53 when rain stopped further play.

GUY'S v. MIDDLESEX HOSPITAL.

SECOND ROUND, HOSPITAL CUP TIE.

Played on St. Bartholomew's ground at Winchmore Hill, on Monday, June 9th, and lost by 46 runs. Our opponents batted first on a slow, sodden wicket, and for

them Heygate played a fine forcing innings. The wicket was cut about considerably when Guy's batted, and Barber and Morres were the only men who offered much resistance to the bowling of Lee and Heygate. Scores :—

MIDDLESEX HOSPITAL.

R. E. Pitts, c Norton, b Wyatt	7
H. G. Brown, b Foster	0
R. B. Heygate, c and b Morgan	42
H. G. Young, c Barber, b Wyatt	43
S. J. Lee, c Morres, b Wyatt	0
A. H. Boys, b Wyatt	0
G. L. Henderson, b Morgan	1
W. J. Bain, hit wkt., b Wyatt	7
R. O. Lee, not out	18
L. A. Fennell, b Foster	1
A. C. Morson, c Bookless, b Morgan	9
Extras	8
Total	134

GUY'S.

H. Barber, lbw, b Heygate	15
E. Morgan, b Lee	14
H. M. Langdale, b Lee	0
H. D. Wyatt, c Boys, b Lee	6
F. Morres, b Heygate	18
E. L. Norton, c and b Lee	5
R. Willan, b Heygate	3
J. Bookless, c and b Heygate	1
E. A. Collins, c Heygate, b Lee	12
M. G. Louisson, not out	6
A. L. Foster, b Lee	2
Extras	6
Total	88

GUY'S v. HAMPSTEAD.

Played at Hampstead on Wednesday, June 11th. Guy's won by 3 wickets and 165 runs. Morgan and Foster bowled well, and were well backed up in the field. Barber played a fine innings, made without a chance, and Morres helped to add 113 for the second wicket. Collins played in good form and was well assisted by Bookless. Scores :—

HAMPSTEAD.

F. Rowley, b Morgan	1
L. Dudley-Smith, b Foster	6
F. J. Potter, c Foster, b Morgan	0
M. Said, b Foster	0
E. W. H. Beaton, b Foster	10
J. G. Q. Besch, c Louisson, b Morgan	12
A. J. East, not out	20
S. Oxlade, b Morgan	0
L. G. Jeffrey, b Foster	16
R. F. W. Monro, b Hicks	12
S. T. Fradd, b Hicks	11
Extras	22
Total	112

GUY'S.

H. D. Wyatt, b Monro	2
H. Barber, c East, b Beaton	100
F. Morres, b Said	55
R. Willan, b Said	4
S. H. Bones, b Said	24
E. A. Collins, not out	50
E. Morgan, c Said, b Beaton	5
J. Bookless, b Dudley-Smith	19
Extras	18
Total	277

J. T. Hicks, M. G. Louisson, A. L. Foster, did not bat.

GUY'S 2ND XI. v. CITY OF LONDON SCHOOL.

Played at Honor Oak Park on Wednesday, June 11th. The game ended in a very easy win for the Hospital by 125 runs. Score :—

GUY'S 2ND.

S. C. Bowle, b Norman	6
A. M. Tollhurst, not out	51
A. H. Turner, b King	2
F. N. Fox, b King	14
G. Gibson, b Markham	50
C. W. Alcock, b Busfield	0
G. Carlisle, b Busfield	6
—. Allison, not out	6
Innings declared closed.	
Extras	16
Total	151

H. Carter, S. A. Piper, G. Russell, did not bat.

CITY OF LONDON SCHOOL.

N. F. Norman, b Russell	10
F. A. Briggs, b Russell	1
C. I. Bussy, b Carlisle	0
J. R. Busfield, b Russell	0
W. E. Hardman, b Carlisle	4
W. P. Schutte, b Carlisle	2
E. L. Knight, c Turner, b Carlisle	2
A. P. Hall, not out	0
F. Markham, b Piper	3
B. King, b Piper	0
W. G. Luew, b Piper	9
Extras	4
Total	26

Guy's Hospital Lawn Tennis Club.

The first round of all the tournaments must be played off by Wednesday, June 25th. Those who have not played by this date will be scratched. Competitors who have drawn a bye must play off their ties by Saturday, June 28th. The entrance fees are to be paid to C. H. Winckworth.

The matches v. Blackheath on June 7th, and v. Wanstead on June 14th, were scratched, owing to rain

F. W. M. Palmer was selected to play for the United Hospital team v. Cambridge, but the match had to be abandoned owing to rain.

The following is the draw for the Cup Ties. Dates, Wednesday, Thursday, Friday, July 2nd, 3rd and 4th:—

Guy's	—		
Bart's.		—	
George's—bye			—
Thomas's—bye		—	
London—bye			

Ground—Chiswick Park, L.T.C. Play starts at 10.30 a.m. each day.

Appointments.

CIVIL.

Gough, Bernard Bradley, M.R.C.S., L.R.C.P., Lond., has been appointed Medical Officer and Public Vaccinator for the Harptree District of the Clutton Union.

Griffin, Wilfred Ernest, L.D.S. Eng., has been appointed Dental Surgeon to the Royal Hospital, Greenwich.

Hardenberg, Ernest J. F., M.R.C.S., L.R.C.P. Lond., has been appointed Senior Resident Medical Officer to the North-West London Hospital.

Shorland, George, M.R.C.S., L.R.C.P. Lond., has been appointed District Medical Officer of the Westbury Union.

NAVAL AND MILITARY.

Surgeon R. C. G. Reed, R.N., has been appointed to the *Severn* for the *Onyx*, and Surgeon H. G. T. Major, R.N., to the *Galatea* for the *Alarm*.

Colonel G. C. Hall, I.M.S., is appointed to officiate as Principal Medical Officer, Lahore District.

Surgeon-Lieutenant H. W. Webber, from 2nd Devonshire Royal Garrison Artillery (Volunteers), to be Surgeon-Lieutenant, Volunteer Infantry Brigade Bearer Companies.

PRESENTATION.

Mr. R. M. Wallace, M.B. Lond., M.R.C.S. Eng., has on his return to practice in Hackney received from his friends an illuminated address and a cheque for £700.—*Lancet.*

The General Board, University of Cambridge, proposes that Mr. F. G. Hopkins shall be appointed Reader in Chemical Physiology, and Emmanuel College, of which he is a member, has spontaneously offered to contribute £100 a year to his stipend. It is probable that the proposal will be adopted, for Mr. Hopkins, in the position of University Lecturer, has performed services to the University and to science which amply justify his promotion to the higher rank.—*British Medical Journal.*

The name of Dr. C. T. Brookhouse, of Brockley, has been placed on the Commission of the Peace for the County of London.—*Lancet.*

Solution to Case for Diagnosis.

Patient was seen by Dr. Fawcett, who pointed out that the comparative slowness of pulse, and the fact that the symptoms did not increase in severity, were both against acute peritonitis. He suggested colic, and advised enemata and watching. Patient slowly improved, the pain gradually becoming localised to left hypochondrium, until on the evening of June 3rd, when a mucous cast about 2 ft. long was passed per rectum, the patient rapidly improving after this. Mucous colitis was thus the ultimate diagnosis.

Birth.

MEYRICK-JONES.—At Overbury, Charlton Kings, Cheltenham, the wife of H. M. Meyrick-Jones, M.D., of a daughter.

Marriages.

JACKSON—MILNE.—On June 11th, at the Congregational Church, Cheadle, by the Rev. J. W. Paull, M.A., Thomas Leonard Jackson, M.B., son of the late Thomas Jackson, M.D., of Whitehaven, to Emily Margery, second daughter of James Herbert Milne, of Langlands, Cheadle, Cheshire.

PENDLEBURY—HEWETT.—On the 17th instant, at St. Jude's, Southsea, by the Rev. Canon Blundell, of Halsall, Honorary Chaplain to the King, and the Rev. Canon Blake, Vicar and Rural Dean, Dr. Pendlebury, of Knowles House, Ormskirk, Lancs., to Eva Stuart, youngest daughter of the late General W. Selwood Hewett, Bombay Staff Corps. Indian and Argentine papers please copy.

WALES—DOWLING.—On June 11th, at All Saints, Marple, by the Rev. E. Hewlett, M.A., and the Rev. R. Adams, M.A., Edward Garneys Wales, M.A., M.B., B.C. Cantab., M.R.C.S., L.R.C.P., son of Thomas Garneys Wales, Downham Market, Norfolk, to Annie, elder daughter of R. J. Dowling, Beech House, Torkington near Stockport.

Death.

WILSON-SMITH.—On Sunday, 8th June, at 17, Brook Street, Bath, Alice Maud, the beloved wife of Thomas Wilson Smith, M.D.

Ed.—D. G. G.

Contents.

	PAGE
ACUTE PERITONITIS: Clinical Lecture by Dr. Hale White	269-277
ADVICE TO THE YOUNG	277-278
PAPERS BY GUY'S MEN	278
PASSIM	279-281
OBITUARY: John Wyc enfor ; Washbourn; Clemence Margaret Cott n	281-283
NURSING NEWS	283
THE BARBARY JEW	283-284
MEDICINE AND THE MOTOR CAR	284-285
SPORT: The Inter Hospital Sports. Cricket—Guy's v. M.C.C.; Past v. Present; Guy's v. Hornsey; Guy's 3rd XI. v. Camberwell House; Guy's 3rd XI. v. New Eltham. Lawn Tennis—Past v. Present; Gu 's v. Harold	286-288
SOUTH AFRICAN MEMORIAL FUND: 13th Subscription List	288
APPOINTMENTS	288

Calendar of Coming Events.

July, 1902.

Sat. 5.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. Moyle and H. W. Bethell; Cl., H. A. Cutler.
G.H.C.C., I., v. Enfield, home.
II., v. St. Bart's "A," away.
III., v. Syntax, away.

Mon. 7.—1.15 p.m., Clinical lecture by Mr. Higgens.
Opening of the Henriette Raphael Nurses' Home by T.R.H. the Prince and Princess of Wales.
Inter. M.B. Lond. Exam. begins.
First part of Conjoint D.P.H. Exam. begins.

Tues. 8.—Final Conjoint Exam. begins.
Applications to Medical School Office for Schedules for First Conjoint Exam. to be made not later than this date.
August Appointment List closed.

Wed. 9.—1.30 p.m., Clinical lecture by Dr. Shaw.
October Appointment List opened.
G.H.C.C., II., v. Sevenoaks School, away.

Thur. 10.—Messrs. Jacobson and Fripp's take-in; Drs., F. C. Knight and E. L. Ward; Cl., N. N. A. Houghton.

Fri. 11.—1.15 p.m., Clinical lecture by Mr. Fripp.

Sat. 12.—G.H.C.C., I., v. Addiscombe, away.
II., v. Hos. Scho., home.
G.H.L.T.C., v. Kent, away.

Mon. 14.—1.15 p.m., Clinical lecture by Mr. Fagge.
Second part of the Conjoint D.P.H. Exam. begins.
Pre. Sci. M.B. Lond. Exam. begins.

Wed. 16.—1.30 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., v. Wellingboro' Masters, away.
II., v. Thespids, away.

Thur. 17.—Messrs. Symonds and Steward's take-in; Drs. H. B. German and R. Larkin; Cl., C. J. Pinching.

Fri. 18.—1.15 p.m., Clinical lecture by Mr. Fripp.
G.H.C.C., I., v. Eltham, away.
III., v. Christchurch Institution "A," away.
G.H.L.T.C., v. Gravesend, home.

Guy's Hospital Gazette,

JULY 5, 1902.

Acute Peritonitis.

CLINICAL LECTURE BY Dr. HALE WHITE,
May 21st, 1902.

(For the shorthand notes of this lecture we are indebted to the Editor of the CLINICAL JOURNAL*).*

GENTLEMEN,—I have taken the subject of Acute Peritonitis for to-day, because from the very nature of the cases many of you hardly ever see one. The patients are so urgently ill, and operation is nowadays almost the only thing which can save many of them, therefore by the time you come to the ward you find the patient has already been operated upon. Probably most of the cases of acute peritonitis which come in here are operated upon within a few hours of their admission, so that all that you see is a patient with a number of bandages around him or her. The reason why the patient is so severely ill is not difficult for you to understand, because if you will think for a moment you will remember that the peritoneum has an enormous area. The area of the peritoneum is about equal to that of the skin, and hence there is a very large absorptive surface, and effusion and absorption are probably constantly going on in the peritoneum, for, as you know, it is always just slightly moist, so that the friction of the various parts one upon another is rendered very easy. A good deal of work has been done lately on the question of effusion into and absorption from the peritoneal cavity, and some people, I think, have the misconception that the chief determining factor—and they often think the only determining factor—of effusion into the peritoneal cavity is an alteration in the blood-pressure of the portal area. But if you think for a moment, you will

understand that that is not so; for were it so a person with congenital heart disease, and therefore with high blood-pressure in the venous system, should have effusion into the peritoneal cavity. Further, it can be demonstrated experimentally that it is not so; because if you ligature the portal vein you do not get effusion into the peritoneal cavity. But supposing you take a dog in whom you have ligatured the portal vein, and you dip a little piece of intestine into ordinary tap-water, you will find there is effusion into the peritoneal cavity. That experiment, therefore, teaches that while increase of venous pressure will not in itself cause effusion, it is a contributory factor, because the venous pressure being increased, the slight damage to the peritoneum which follows the application of tap-water leads to effusion into the peritoneal cavity. The experiment also teaches you that for effusion to take place into the peritoneal cavity the permeability of the peritoneum itself has in some way to be altered; and even the slight alteration which ensues upon dipping it into tap-water is sufficient to determine effusion into the cavity.

Then, with regard to absorption. Much work has been done of late years with regard to absorption from the peritoneal cavity, and this absorption is undoubtedly very rapid. A controversy has raged around the point whether absorption takes place chiefly by the blood-vessels or by the lymphatics, and that question cannot be said to be settled entirely. Experimenters, introducing large quantities of fluid into the peritoneal cavity have claimed that absorption takes place only by blood-vessels. But since then other experimenters, introducing lesser quantities, have claimed that if you introduce only a small amount, absorption takes place by means of the lymphatics. The introduction of a smaller amount of material is much more comparable to what is constantly happening in peritonitis than the sudden injection of many ounces of fluid into the peritoneal cavity. There are at least three factors concerned in absorption from the peritoneal cavity, all of them probably of importance in connection with peritonitis. And, first, I would mention what we know little about, namely, absorption by means of stomata between the cells lining the peritoneal cavity. Another factor is filtration, and that will depend on the pressure within the peritoneal cavity. Hence it is important to remember, in connection with peritonitis that intra-abdominal pressure is greatly increased by the movements of respiration. These are very much lowered in peritonitis, and so absorption is retarded; on the other hand, it will be increased by the distension of the intestines with gas, which often takes place in peritonitis. And the third factor which you have to do with is osmosis, which varies inversely with the alterations in the specific gravity of the fluid which is about to be absorbed. Of course, only hypotonic fluids can be absorbed by osmosis, and, generally speaking, the rate of absorption of a hypotonic fluid increases in the inverse ratio of its concentration. We cannot here discuss furthur the many difficulties connected with throughly understanding the question of peritoneal absorption. They merge into the discussion of the differences between vital and physical processes.

With regard to two little points in connection with man. It appears that, at any rate in man, much absorption takes place by means of the lymphatics of the diaphragm, and the glands in the anterior mediastinum are secondarily affected in acute peritonitis, absorption taking place through the lymphatics of the diaphragm, and being passed on into the lymphatic glands of the anterior mediastinum. And the other factor which you are likely to forget in thinking about acute peritonitis is the great importance of the omentum. When he was Gull research student, H. E. Durham made many investigations, and showed that in cases of acute peritonitis the process often first attacks the great omentum, and post-mortem the greater part of the disease may be found to be connected with the omentum, and not with the rest of the peritoneum. So you have not made a post-mortem on a case of acute peritonitis properly unless you have carefully investigated the omentum. Also it has been shewn recently that the omentum is of great value in another direction, namely, it is an organ which is used by Nature largely to attempt to heal cases of peritonitis, for if there has been a rupture of any viscus it is not unusual at the

post-mortem to find that the great omentum has applied itself to the rupture, and has apparently attempted to seal it.

The next thing necessary to consider when you are thinking about acute peritonitis is the following. You cannot form a proper conception of a case of acute peritonitis unless you have some clear notion in your mind as to its etiology. When I was a student it was a much disputed point whether there was such a disease as idiopathic peritonitis. Now it is generally admitted there is no such disease as idiopathic peritonitis; but only quite recently I saw in one of the journals an attempt to resuscitate idiopathic peritonitis, the author suggesting that many of the cases of so-called rheumatic peritonitis were idiopathic. But unfortunately for that notion, as clinical observers we know nothing of the so-called rheumatic peritonitis; it is always a diagnosis covering ignorance, there is no evidence of it whatever, and I have been to the trouble to look up the accounts of many of the older cases of so-called rheumatic peritonitis, and none of them which I have come upon will bear modern-day criticism. For instance, there was a case recorded by Dr. Fuller, who gave an account of what he called rheumatic peritonitis; but as the patient had had pneumonia also there is little doubt that nowadays that would be regarded as a case of pneumococcal peritonitis. So I must ask you to dismiss from your minds any such diseases as idiopathic peritonitis, or rheumatic peritonitis.

I have written out a list of various micro-organisms which are the cause of peritonitis. I will write them on the board. As you know, the most common micro-organism as a cause of acute peritonitis is the bacillus coli communis. That is very frequently found. There is also the streptococcus pyogenes, which is almost as common as the bacillus coli communis. Then, but considerably less frequently there are staphylococci, pneumococci, and gonococci. Much rarer organisms which may be found in the condition are the micrococcus lanceolatus, the bacillus proteus, bacillus aërogenes capsulatus, bacillus pyocyaneus, and bacillus typhosus. It is important to remember that a pure cultivation of bacilli from the peritoneum is rare; most cases of acute peritonitis are mixed infections. It does not matter at all how these micro-organisms are introduced into the peritoneal cavity. The simplest mode of production in man would be a stab with a dirty dagger, and occasionally acute peritonitis is produced in that way. But that is of course quite the exception, at any rate in this civilised country. The way in which acute peritonitis usually arises in England is by perforation of some hollow viscus within the abdomen. In order to show you the importance of that, I may mention that I came across a collection by Jantz, of twenty-one cases of perforation-peritonitis, and it will be a matter of great clinical interest for you to see how they group themselves. Out of the twenty-one, seven followed perforation of the appendix; five followed perforation of a gastric ulcer; three followed perforation of a typhoid ulcer; two followed hernia; one followed rupture of the stomach; one followed rupture of the intestine; one from rupture of a duodenal ulcer; and one from rupture of a perimetritic abscess. That I think, represents with sufficient accuracy the relative frequency of the causes of ordinary clinical perforative peritonitis. Certainly it corresponds with my own clinical experience, for in that the commonest cause is perforation of the appendix; the next commonest is perforation of gastric ulcer; the next, perforation of typhoid ulcer; and then there are the rarer causes. But all sorts of rare causes may lead to the condition. For instance, I have seen perforative peritonitis secondary to a suppurating lympathic gland, which gland was suppurating because of an inflamed pile.

The next most frequent cause of acute peritonitis is infection through the female genital organs. You know that is very likely to occur, because of the Fallopian tubes opening out as they do. Some years ago that form of this variety of peritonitis, which is called puerperal peritonitis, would have been regarded as more frequent than perforation peritonitis. But that was in the days before it was learnt how important it was to have cleanly methods of midwifery. With that recognition there has been a great improvement in the figures of puerperal peritonitis. But I will give you some figures for the

years 1875 to 1885 from the Charité Hospital in Berlin. There the number of cases of puerperal peritonitis was 176, as against 152 of perforative peritonitis. The micro-organisms most frequently found in puerperal peritonitis are streptococci, as you would expect, and the bacilli coli communis is also present. In some cases gonococci are found also. Puerperal peritonits is not the only form of peritonitis which you would be likely to get from infection by means of the female genital organs. Occasionally gonorrhœal peritonitis occurs. Usually that is not a very severe form, and it has been said that it may be a pure infection. Some observers claim to have produced pure gonorrhœal peritonitis in animals; but it is probable that in human beings gonorhœal peritonitis is usually a mixed infection. Although rare, it is a condition which you have to be on the look out for in women.

But even this does not complete all the forms of peritonitis which we meet with clinically; experimental research has shown, as you would expect that bacteria may sometimes pass through the wall of the intestine, even when no perforation has occurred. Clinically, in medicine we recognise that as happening in two common diseases. There may be an acute general peritonitis following upon disease of the appendix without any actual perforation of the appendix. In such a case the bacilli coli communis may pass through the damaged wall of the appendix and set up a general acute peritonitis; and you certainly can get, occasionally, a peritonitis following upon typhoid fever without any actual perforation. In such a case the micro-organisms pass through the thin injured wall of the gut and set up peritonitis. Only quite recently I came across a collection which had been made of such cases. Then, too, there are the rare cases in which actinomycosis affects the peritoneum. That is another instance in which the micro-organism passes through the wall of the gut without forming any actual hole—at all events, one which is to been seen by the naked eye—and peritonitis follows.

Now, you see all these forms of peritonitis—traumatic, perforative, through the female genitals, and those in which micro-organisms pass hrough the wall without there being a hole in it, are all forms of peritonitis produced locally, and acute peritonitis usually occurs without there being any disease outside the abdominal cavity. But you may have micro-organisms, part of a general infection, conveyed by the blood to the peritoneum, and they may pass through the vessels into the peritoneal cavity, and thus set up general peritonitis. Instances of that are pneumococcal peritonitis, about which there has been much written of late years. I find that Netter, in 140 observations on peritonitis, found it to be pneumococcal twice; this form may be secondary to pneumonia; or, in still more rare cases, of which we have had one here in the last few years and recorded by Dr. Bryant, it may be a pneumococcal peritonitis without any pneumococcal infection of any other part of the body.

But even this does not finish the etiology, because you have much to think of besides your micro-organisms when you are thinking of acute peritonitis. There is no doubt that many and many a time micro-organisms get into the peritoneal cavity without any peritonitis following. They probably do so in many an operation, however careful the surgeon is, but the micro-organisms die within the abdominal cavity if there is no suitable medium for them to flourish in. Hence, if the absorptive power of the peritoneum is very good and quick, it is possible that any fluid which may be there and might form a growing medium for organism, is absorbed, so that the micro-organisms die because they have nothing to grow in. Again, you have also to remember that the resisting power of the peritoneum varies very much. There is on record the case of a mass of fæces in the peritoneal cavity getting completely encysted; such was the resisting power of the peritoneum in that case that only a local peritonitis followed. On the other hand, sometimes the resisting power of the peritoneum is very low. You see that strikingly shown in the acute peritonitis which is one of the recognised terminations of Bright's disease. Again, you see it when not only the resisting power of the individual is lowered, but when the local resisting power of the peritoneum is lowered. For instance, it is not uncommon for the terminal event in tubercular peritonitis

to be the onset of acute peritonitis. That is an instance of the local resisting power of the peritoneum being lowered.

Another point you have to think of in connection with acute peritonitis has been much discussed by the experimentalists, and that is, whether chemical irritants can set up an aseptic peritonitis. That is interesting to laboratory workers, but it has very little clinical interest. In the laboratory it is said to be possible, but it hardly ever occurs clinically. There are one or two cases on record, for instance, in which it has been claimed that aseptic peritonitis has followed from the irritation produced by the bile in a case of rupture of the gall-bladder from traumatism; but they do not count for much, I think, because we know that the bacillus coli communis is a very, very frequent inhabitant of the gall-bladder; and I should want strong evidence to show that a peritonitis in such a case was sterile, although it is only fair to add that some experimenters claim to have produced sterile peritonitis experimentally in rabbits by injection of sterile bile. Bearing on this question you may remember that cystic adenomata of the ovary may rupture into the peritoneal cavity. Grafted on to the peritoneum are adenomatous growths. In such cases often there is no general peritonitis, and it looks as if that were an instance of sterile irritation of the peritoneum without resulting general peritonitis. The last point in connection with this subject, which is worth mentioning to you, is that it has been said that sometimes the fluid in the peritonitis which occurs after strangulated hernia is proved to be bacteriologically sterile. If that is so we must suppose that the peritonitis was set up by the toxins which were transmitted through the gut. So I want to impress upon you that the result of all this is that clinically we hardly know of any peritonitis that is not due to micro-organisms, and that clinically by far the most important cause of the introduction of these micro-organisms into the peritoneal cavity is perforation of a viscus, and the next most important cause is entry of organisms through the female genital tract. If you now have these facts firmly fixed in your minds you will have done a good afternoon's work.

I do not pretend that this is a systematic lecture, so I do not propose to give you all the symptoms; but I think I might do you some service if I directed your attention to some important points about the symptoms which may help you. All the books try, and often with great success, to give a graphic description of a patient suffering from peritonitis. The first thing that every book tries to give you is—and quite correctly, and this is very important for you to get hold of—that it is in very nearly all cases a disease of sudden onset. The patient is suddenly taken ill. A woman may wake up in the morning apparently quite well, and by the evening may be at death's door. So that the great thing to grasp in your minds is that peritonitis, certainly in almost all perforative cases, is a condition which quickly brings the patient to the edge of the grave, or passes her into it. With regard to the aspect of the patient, that is very important. Text-books give you a graphic and well-painted account of the appearance of the patient; the sunken eyes, the drawn features, the livid and yet pallid complexion, the look of anxiety; altogether the sort of face that the practised physician well knows shows what is the matter with the patient. I admit that in the majority of these cases it is present, it is very striking, and it is important; but you will commit a grave error if you go away with the impression that it is always present. You must not refuse to diagnose peritonitis because the characteristic look is absent. You may see a person who is only a few hours from death looking calm and comfortable; there may be nothing whatever in his appearance to attract your particular attention.

There are few diseases in which more is to be gained by simply looking at the patient. The physical examination in such cases helps little compared with looking not only at the face, but turn down the bed-clothes and look at the patient. The first thing that will occur to you is that, as the books tell you, the abdomen does not move on respiration. That is very true indeed; as a rule the abdomen is perfectly immobile, and that fact is most important for diagnosis. But occasionally it may move a little, and then you may sometimes hear a rub over it from the

inflamed surface rubbing against the inflamed parietes. Another thing which is very important is, do not be carried away by want of distension. I admit that the usual sequence of events, after a perforation has appeared, is that the abdomen becomes at first retracted and the muscles hard and rigid as though they were contracting down upon the perforation and trying to compress and seal it. But usually that passes away, the intestines become paralytically distended, gas accumulates in them, and consequently the abdominal distension is enormous. Do not go away under the impression that the rigidity and retraction of the abdomen always passes away. I have seen a patient die before any distension occurred. You ought to regard persistently rigid retraction of the abdomen as quite as important as distension, and remember that sometimes it is not succeeded by distension. Of course, you know the importance of observing whether the legs are drawn up. Also, in order to help the muscles of respiration, as the breathing is done by the thorax alone, the patient usually lies in bed with her arms thrown back on the pillow. The tenderness in these cases is often very extreme. If you go into the wards where there is a patient suffering from acute peritonitis, and who has not yet been operated upon, you often see a cradle over the bed. There is extreme tenderness and cutaneous hyperæsthesia with it. The pulse is a matter which it is very important to remember. It is usually a rapid, small, thready or wiry pulse, becoming more rapid and smaller and smaller as the case goes on, until when the patient is about to die, the pulse becomes almost uncountable at the wrist, and it can hardly be felt at all.

I have already pointed out to you that the respiration is shallow, and as the abdomen moves but little it is rather a rapid respiration. It is important to note that. The temperature does not help you very much, for this reason: the first effect of the perforation, the shock, is liable to depress the temperature; and so when you first see the patient he is collapsed, and it is only when the period of reaction sets in that the temperature mounts to the normal. Then, as a rule, it gets well above the normal. But the exceptions are so numerous that you cannot depend much upon the temperature to help you in the matter; but it is true that if it is very much raised or very much depressed, those two facts will help you. The first reaction from the collapse follows the influence of the toxemia, due to the absorption from the abdominal cavity. The patient frequently vomits, and it is an important point to remember that the vomiting naturally tends to stop. But that does not mean that the patient is better. Even if the vomiting stops, the patient often continues to retch, and towards the end he will bring up brown fæcal-smelling matter. A common cause of death in these cases is for the fluid which is regurgitated to get into the lungs and kill the patient.

Next, do not go away with the impression that these patients are always constipated. There may be considerable diarrhœa present, and that is an evidence of the degree of toxemia there is in the case. Patients may also complain of difficulty of micturition. Another important thing to remember is that, unfortunately for the patient, his mind usually remains clear until the last minute before death. Nowadays you would rightly attach much importance to the examination of the blood. There are few diseases except pneumonia in which leucocytosis is more rapid than it is in acute general peritonitis. Counts showing as many as 100,000 leucocytes to the cubic millimètre have been recorded, and the increase is chiefly in the polymorpho-nuclear leucocytes. It is a matter of very great importance to take a blood count, for this reason. You know that typhoid is one of the specific fevers which does not lead to leucocytosis; so if you have a typhoid case and there is sudden leucocytosis, it is a considerable point in favour of the view that some perforation has taken place.

These are the symptoms which I wanted to call your attention to. And other practical points in connection with it are these. As Mr. Symonds pointed out in a lecture he recently gave, a circumstance which, especially to the surgeon, is of great importance, is as follows:— The first thing which occurs after perforation is great shock. The patients become very suddenly ill, that is to say, within a few hours. But they

make an attempt to rally, and, compared with their serious condition, they may, at the end of twenty-four hours, feel so improved that they themselves declare that they are very much better. A period of reaction or repose, as the patient calls it, sets in, which, compared with the previous collapsed state, is apparently very satisfactory. But that is really a most dangerous period, because the unwary are inclined to say that the patient is really better, and, consequently, they do nothing. When you have a case of that sort before you be very careful to see whether the *local* signs are any better. That is to say, is there still retraction, is there distension, is there local tenderness, is there rigidity? It is by the local signs you will be able to tell whether the period of reaction or repose indicates that after all it was only a serious attack of colic, and not a perforative peritonitis which you had to deal with. If you see the patient in that period of repose and you fail to give it its proper significance you may say I will not operate, and you may come next morning and find the patient dead or dying.

The other point I wanted to direct your attention to is, that in certain patients acute peritonitis gives no symptoms at all. When a man is all but dead you cannot expect many symptoms to be manifested in him. Symptoms indicate a certain amount of reaction; if the poor patient is moribund he cannot feel pain, and so it is not infrequent in acute peritonitis to miss the real trouble. I remember missing it, for instance, in a case of malignant disease of the bowel. Perforation occurred, and the patient died of peritonitis, but he was almost moribund from the malignant disease. He complained of no pain, and had no symptom pointing to peritonitis. I have known the same to occur in typhoid fever.

The duration of peritonitis varies very much. I have here a record of the duration of seventy-seven fatal cases of peritonitis collected by Treves which I thought might interest you, as showing how rapidly the subjects of this disease die. He found that in fourteen death occurred within thirty-six hours; in six death occurred within thirty-six to forty-eight hours; and in twenty death occurred between the third and fifth day. That is to say, in nearly half of them, people, often previously apparently healthy, were dead on the fifth day. In 33 per cent. death took place between the fifth and seventh days, and 27 per cent. with the seventh day. That will give you some idea of the severity of the disease with which we have to deal.

The prognosis is very grave indeed. The outlook for such cases is improving, because surgery is improving. Acute peritonitis is generally said to have a mortality of about 80 per cent., but that very likely understates the case, because it is possible that some had not got it who were thought to have it, or the peritonitis was local. In perforative peritonitis, the prognosis, apart from operation, is almost hopeless. In the cases which spread from the female genital organs, the prognosis is a little better. Not long ago I saw a case of gonorrhœal peritonitis get perfectly well without any operation.

Another thing which troubles you much when you are called to a case is the diagnosis. I do not believe in writing out lists of things by which you can tell the diagnosis of one disease from another. I believe that the best way to prevent mistakes is to be aware of the possibilities of the errors which you are likely to make. Therefore I have jotted down for you the things which I have known acute peritonitis to be confounded with. They are:—intestinal obstruction, intestinal colic, hepatic or biliary colic, renal colic, lead colic, cholera, dysentery, ulcerative or other varieties of colitis, acute pancreatitis, twisting of ovarian pedicle, ruptured extra-uterine fœtation, pleurisy, and pneumonia. All those things I have seen confounded with acute peritonitis. I think if, when you see before you a case of acute peritonitis, you bear that list in mind, you will be much more likely to avoid making mistakes than if you merely get up a list of distinctions.

The next thing to pass on to is the treatment. In the great majority of cases absolutely the only thing to do is to hand the patient over to a surgeon, to ask him to open the abdomen and deal with the perforation. As far as we know, perforative peritonitis never gets well apart from interference by the surgeon. It is essentially a condition in which time is everything. An hour saved adds greatly

to the chances of the patient's recovery, so that it is a condition in which you must act promptly. That is why so few of you ever see a case in the acute stage; by the time you get into the wards, the patient has been operated upon. But to many of you it will often happen that for some reason or another the patient cannot be operated upon. There are probably many occasions in which, in some out of the way part of the world, there may be no facilities for operating upon a patient; or again, the patient may refuse to be operated upon; or, as unfortunately sometimes happens, the patient is too ill for the surgeon to care to operate. He says, not unnaturally, that the operation will only hurry the end. So we must think of the treatment in cases where the operation cannot be or is not performed. I should have added that another reason why operation is not performed is that in some of the milder cases following upon infection through the female genital organs, surgical interference is not called for. In the interesting case of gonorrhœal peritonitis which I have referred to, the patient was not ill enough to warrant operative procedure being suggested, and she got quite well. So supposing that for some reason or another the case belongs to the few for whom no operation is required or cannot be done, what shall we do? Of course it is absolutely essential that the patient should be put to bed, and kept on the back, quite at rest, and there must be a cradle for the bedclothes to rest upon to keep their weight off the abdomen, and the woman should have a pillow under her feet so as to rest her legs when they are flexed up on the abdomen, that being the position which is most comfortable for her.

It is a short illness; the patient will probably either die or be much improved by the end of a week. So that the quantity of food is not a matter of very great importance. Rest to the abdomen is more important than food. I have pointed out to you that such patients are generally sick at the beginning of the illness, and that they suffer much from nausea and retching. So you will usually give very little or nothing by the mouth, and you will therefore have to feed by the rectum. You want to feed the patient as rarely as possible, so that you may disturb her as little as you can. Thus large enemata are better to use than small ones, and those mentioned in the GAZETTE by Dr. Beddard are excellent. For example, somatose 3½ oz., dextrose (5·8 per cent. solution), 9 oz. is a good enema. Another made of 9 fluid oz. starch and water, with the white of three eggs, with 40 grs. of salt to the 9 oz. is good. Do not use nutrient suppositories, because they have little nourishment in them. You cannot often move a patient with acute peritonitis; but when you have passed the soft tube high up, try and tilt the patient upwards, or raise the end of the bed, so as to get the enema to flow a long way up. And then you will be much more likely to get the enema absorbed if you first of all wash out the bowel with a little saline solution. There is another point which is not sufficiently thought of. These patients are very sick, so that they quickly lose much fluid, and hence one reason, I think, why many of them are as ill as they are is because they have not got enough fluid in them. So you should do one of two things; either some time when you are not giving your enema throw a quantity of normal saline fluid into the bowel, or transfuse a salt solution into the cellular tissue about the axilla or under the breast. Do not let the patient die for want of fluid.

The mention of vomiting reminds me of the treatment of that. It is very difficult to treat it. Fortunately it often stops of itself. Of drugs, I think dilute prussic acid in a little effervescing mixture is good, or drop doses of tincture of iodine. But I am sure that often vomiting may be relieved by washing out the stomach. As a rule, men are afraid to do that in cases of peritonitis; they say surely it will make matters worse. But if you let these patients go on vomiting they will die, and I have not seen any harm follow washing out of the stomach, provided there is not a hole in it, and by that means you are able to get rid of the filthy brown stuff which, if absorbed by the stomach, must be very bad for the patient. Do not forget that sometimes vomiting is due to the opium which you are giving. Another matter is the giving of ice to these people. Many of these patients are allowed

to be constantly taking up ice to suck. Think of the loss of energy that the melting of ice means. Every time the patient gets a piece of ice and sucks it there is so much heat abstracted from the body. Cut down the ice as much as you can; there is no real reason why they should have it at all. Certainly the less they have the better for them. You will try to keep the mouth clean by tincture of myrrh and borax.

I have left to the last the question of the giving of opium. Surgeons frequently object to the giving of opium, and say they wish it had not been done. And they are quite right, because I have pointed out to you that the majority of cases of acute peritonitis will pass to the care of the surgeon and require laparotomy because of the peritonitis, but the opium has naturally dulled the symptoms, and so by the time the surgeon sees the patient he is less likely to diagnose whether there has been perforation or not. All that is true, but I am supposing you are dealing with one of those few cases in which there is no perforation, in which there is no operation going to be done. If there is no operative interference contemplated you must thoroughly push opium, for this is your best chance of saving your patient. The gain which you have by that means is immense. You paralyse the bowel and keep it still, and keep the inflamed parts at rest, and thus enable adhesions to form and for recovery to take place. The patient should be kept gently under the influence of opium. And when you are observing whether or not you have given enough opium, do not direct your attention chiefly to the respiratory movements, because owing to the peritonitis the respiratory movements are less. So you may think you have given enough opium when in reality you have not. In these abdominal cases the guide as to the quantity of the opium is not the abdominal movement, but the state of the pupil. The best way to give the opium is to put the requisite quantity of tincture of opium into the enema which you are giving, and give such a quantity that the patient is kept under its influence, so that he is always a little drowsy. If you will treat a case which for any reason cannot be operated upon like this, you will find that fortunately it may sometimes get well.

Advice to the Young.

MANY praiseworthy efforts have been made to direct raw youth to the narrow way and to arrest his career along the more popular broad path before he has gone too far. Galateo, Chesterfield and Cobbett, to say nothing of Mrs. Humphry, have all striven to instil manly principles and to teach him the rules and customs of society, and such other things as are necessary for his moral and social well-being.

That we may not be thought apathetic to the interests of the younger generation, we have appended below some paragraphs taken at random from the Letters of Lord Chesterfield, and have, in our own homely way, explained them illustratively, in the hope that some profit may accrue to those in quest of a mentor.

"Every action and every gesture should be such as may testify the greatest respect and esteem for the persons with whom we are in company."

To quiz or befool a man when others are present is unpardonable. For instance, never ask a doctor in the hearing of your friends whether he keeps a stock bottle, or a lawyer whether he believes in the doctrine of eternal punishment. These cheap Millerisms will not raise the standard of professional morality, nor will they make your name as a wit. Further, in company you are advised that "private scandal should never be received nor retailed willingly." If you hear that a certain lady's reputation is a trifle damaged, affect not to listen, or turn the conversation to the weather. In the event of your being obliged to give credence to the assertion, do not publish the fair one's indiscretions from the house-tops, but keep them locked in the innermost recesses of your mind.

Don't give ear to the suggestion that Mr. Smith's proper place is Portland, and not Capel Court. Smith may be quite a decent kind of fellow in his way, and perhaps, at some time or other, will do you a good turn; then what will his mis-choice of residence matter?

"Avoid as much as you can, in mixed companies, argumentative, polemical conversations."

It is an invariable rule that religious and political questions should be excluded from conversation in social circles. Nobody wants to know your personal views upon the Procedure rules or the Education Bill. Still less do they wish you to hold forth on predestination, or the authenticity of the Pentateuch. If, however, you can't resist, avoid broaching matters which you have reason to believe will prove distasteful to your hearers; and if you think your dear friend Mr. Kroodger should be canonised, keep it to yourself. A great thing in "argumentative polemical conversations" is to swim with the current, and to oppose the noisy minority. It need hardly be mentioned that to show heat in a debate is bad form. Big D's should not be flung around, as they are more befitting Covent Garden or Westminster than a

drawing-room, and reflections upon your opponent's sanity are equally objectionable.

"Swearing without having a single temptation to plead is as silly and as illiberal as it is wicked."

This being an article expressly written for the uplifting of young men, we must warn them against contracting the habit of cussing; but at the same time a playful little oath just once in a way to break the monotony of life, although it can never be justified, may, we opine, be excused if just cause arise for its use. However, the advice is in the main good; although the assertion that swearing has no temptation to plead may not be quite in accord with the opinion of those of us who claim to be human.

"Tell stories very seldom and absolutely never but where they are very apt and very short."

If you can tell a story in a free and natural manner do so. If on the other hand you are nervous or your speech is affected, leave the story telling for others; as a man who struggles through an anecdote while beads of sweat chase each other down his brow, makes a pitiable figure and is regarded by the company with mingled feelings of mirth and compassion. Remember to adapt your stories to your listeners. Do not refer in the presence of ladies to the association of a ruddy blush with the speed of a motor-car, nor on any account to the office boy's orthographical shortcomings. Such delicacies must be reserved for acquired palates. Scriptural wit requires very careful handling. Leave it alone is what we advise. The garrulous old gentleman in the corner whose after-dinner conversation proclaims him to be past blushing, may be the first to take exception to a biblical jeu d'esprit.

"Sottish drunkenness, indiscriminate gluttony, are infinitely below the honest and industrious professions of a tailor and a shoemaker."

The above is not very happily expressed, but the meaning is clear. Drunkenness depraves the heart and slugs the liver. Gluttony, too, affects the liver, and to a very much larger extent than its sister vice, although its evil does not extend to the seat of the affections. In days gone by hard drinking in company was considered quite *comme il faut*, and it was no uncommon thing after the toasts for the male portion to vacate their seats at table and repose in helpless bliss on the floor. Fortunately times have altered, and any tendency towards topsy turvydom after dinner means to the offender social damnation. Further, over-eating is almost as bad socially as drunkenness; and if, by the voracity of your appetite you lead your host to suspect that you have been in training upon gin and bitters for the purpose of doing honour to his table, he will not appreciate this mark of respect, and will hesitate before again requesting the pleasure of your company.

"Frequent and loud laughter is the characteristic of folly and ill-manners."

A man should study to avoid giving open vent to his feelings by contortions of his facial muscles. Laughter may be fat-forming and beneficial to the lungs, but why a perfectly healthy body should indulge in explosive guffaws because, forsooth, something tickles his silly sense of humour is beyond us to discover. The Darwinian theory declares us to be the glorified seed of monkeys, which may be some excuse for these indulgences, but the sooner we shake off the unpleasant habits of our quadrumanous ancestry the better.

"Be upon your guard against those who upon very slight acquaintance obtrude their unasked and unmerited friendship and confidence upon you."

This is, in another dressing, the advice of both Æsop and Shakespeare, so we quote on high authority. Of course in your endeavours to follow this precept you must not let your suspicions fall indiscriminately. Murder and theft do not necessarily follow upon proffered friendship, and because a man in the train offers you the *Christian World*, it should not be too readily assumed that he wishes to bespatter the cushions with your brains, or indulge in other ungentlemanly behaviour.

To secure a friend is to secure a treasure, but before you grapple him to your soul with hoops of steel, be sure he is worthy the process.

"It is very difficult to fix the particular point of economy, the best error of the two is on the parsimonious side."

There is no objection to letting your light shine before men, but its brilliance should be in accordance with your means. To found a hospital or a home for Hooligans, though no doubt a very meritorious act, must be far beyond the dreams of most men's benevolence, and if you scatter your sheckles broadcast in the cause of charity and then leave your dear wife an annuity of £50, and your son John Thomas your gold Geneva watch, with assets barely sufficient to pay the undertaker, won't Johnny and his mother just slang you when you've made your exit. But if your almsgiving be within reason, and your nearest and dearest properly provided for, you will leave no one behind to howl anathemas over your dust.

General comportment at table, the care of the person and other apparently minor matters, although not mentioned above are of great importance and must claim your most serious attention; otherwise, you may be a veritable Joseph possessed of a hundred and one standard virtues and yet never take rank as a man of polish and refinement.

LE CONSEILLEUR.

Papers by Guy's Men.

The Pathology of Certain Growths about the Lower Jaw. By J. H. Targett, M.S., F.R.C.S.—*Transactions of the Odontological Society of Great Britain* for May.

A Clinical Lecture on Acute Peritonitis. By W. Hale White, M.D., F.R.C.P.—*The Clinical Journal*, June 25.

Fractures of the Radius and Ulna. By W. Arbuthnot Lane, M.S.—*Ibid.*, July 2.

Passim.

The general gloom thrown over the country by the illness of the King has been to a large extent swept away by the favourable turn events have taken during the last few days. Everyone was preparing for the greatest pageant of modern times, and the unforeseen occurred, which shattered the nation's hopes at a blow. The King, who has done perhaps more than any other sovereign for the alleviation of suffering and illness, was himself laid low, and the whole of the Coronation ceremonies postponed. Naturally all his subjects were grieved and disappointed beyond measure, but those connected with this hospital, for which the King, while President, did so much, were interested especially, and most cordially wish that His Majesty may be speedily restored to health.

Guy's has indeed passed under a deep shadow in the days which have just gone. Besides participating in the general disappointment of a nation, we have sustained two most serious losses by the deaths of Dr. Washbourn and Miss Cotton, sister in Queen ward. Sister Queen was indeed one of whom we might justly be proud. She worked unceasingly and never spared herself, not even at a time of great personal bereavement. Always at her post, her kindness to the patients in her ward a bye-word in the hospital, she endeared herself to all who had the pleasure of working with her. For some time it has been apparent to all that she was seriously ill, yet she worked on right up to the time when she had to undergo an operation. Although this in itself was successful, we all learn with great grief that her strength, already taxed by her constant exertions, was failing, and that she had not sufficient to rally from the effects of the operation. Now that she is dead, we feel that in her we have lost a nurse whose kindness and devotion to duty stamped her as one of the noblest of her sex and profession.

Dr. Washbourn was followed to his grave in Tunbridge Wells Cemetery a week ago last Tuesday by a small party of Guy's men. The funeral was almost private and of the simplest, as he himself would have wished it. The notice of his life which we publish in the present issue, will show to anyone who did not already know, what a great man we have lost in Dr. Washbourn. His professional attainments, and his work in scientific research, speak for themselves, but it was perhaps in his social relations with the men here that he became the friend of all of us. Ever ready with counsel for those who asked, a strong supporter of all that goes to make a hospital life cheery, he was at once a scientist and a sportsman. No one could enter with greater enthusiasm than he into games, and the trammels of his profession laid aside, he took a deep interest in our various sports, particularly tennis, and was a player of more than ordinary skill. Anyone who knew him when in Africa can testify to his extraordinary fondness for sport of all kinds, and it was to this, as well as to the excellence he displayed in his profession that he attained such great popularity while serving with the Imperial Yeomanry Hospital. It is difficult to do justice to the memory of such a man, and any notice of him is sure to appear meagre when we consider the many sides of his character.

We hope to be able to publish a portrait of Dr. Washbourn in the same style as those of various members of the Staff which have previously appeared.

The list of honours already published, which was to have commemorated the Coronation, contains, we are glad to see, a good proportion of names great in the medical and surgical world. Of course we all assumed that the President of the Royal College of Surgeons would be honoured, and now that the assumption is justified, we hasten to congratulate Sir H. G. Howse on behalf of all Guy's men on the title which he has so justly earned.

The following resolution was passed by General Court on first meeting after resignation of Sir Henry Howse. Resolved unanimously:—

"That Mr. Howse having now resigned his position on the Acting Surgical Staff, be and he is hereby appointed Consulting Surgeon to the Hospital."

The Governors take this opportunity of placing on record their high appreciation of the distinguished service rendered by Mr. Howse to the Hospital and Medical School during the long period of his service on the Acting Staff. They desire to offer him their hearty thanks for his conscientious and regular discharge of the responsible duties that have been required of him, and beg his acceptance of their good wishes for a further lengthened connection with the Hospital as a Member of its Consulting Staff.

NEVER has there been such a healthy festival as the Biennial Dinner. We have all of us witnessed the birth and the puling childhood of numerous year clubs, destined too often to an early and unregretted decease; no one, however, who has attended the famous Biennial Dinner can fail to be struck with the vigorous life which is displayed by this Guy's reunion. The very latest of the series was held at the Whitehall Rooms on Tuesday last, under the presidency of Dr. Galabin, and gave evidence to less mathematical minds than the Chairman's that the series was infinite. Men of all ages, years and pursuits, grey-beard fellows and downy-chin licentiates, acknowledged the general tie of the old hospital, and consorted together in cheerful harmony. The dresser smiled on his surgeon, and forgot the weary colonnade; the surgeon beamed on the dresser, and wished he were a boy again; and all was peace. Truly a triumph of administrative skill and a joy to the Secretary. Of the speeches, which were many, and of the goodly congregation, we shall give a full account in our next issue. Suffice it now to record Dr. Pitt's triumph in his secretary-ship.

THE Past v. Present cricket match is the chief social function of our cricket year at Guy's, besides being an important game, and this year's match was no exception. The Past, although not so strong as some of the former teams, had a good side out, but our present team put up a big score, and although a heavy shower shortened the time available for batting for the Past, some of the old-timers shewed that they had not lost their cunning. The game was drawn, and then as in former years, both teams, besides a number of other visitors, dined at the College as the guests of Mr. Brailey. Not the least important occurrence was the expression of the good wishes of everyone to K. B. Alexander, who by this time is married to Miss Creighton, formerly Sister Stephen. They are both on their way to the Cape, where they intend to settle, and the GAZETTE can but wish them the best of health and prosperity on behalf of many old friends at Guy's.

ON Monday night the glad news of the good progress of the King was celebrated by bonfires in many parts of the country, and some energetic spirits at the hospital made a most successful attempt in the same direction. In a good cause they commandeered a number of barrels from the works department and a sufficiency of tar to make a very respectable blaze, and at the same time to ornament the colonnade pavement. Attracted by the blaze, a good crowd turned up to celebrate the occasion, and chaired the going-off residents round the quadrangle in the time-honoured way.

ONCE more we are disappointed in our efforts to recapture the Athletic Shield, the possession of which was retained by St. Bartholomew's. We had a good team to represent us, but unfortunately Morgan was not in his true form, or he should have carried off the sprints which would have given us the victory. He, however, won the long jump as anticipated, and two more of the events went to our credit, viz., the quarter mile by a fine effort on the part of Allen, after his recent indisposition, and the hammer, which was won by Rankine. As it is we must comfort ourselves with the rather barren hope that we may do better in the future.

WITH the end of a quarter old friends at Guy's leave us and their places are taken by those whom each fresh appointment list brings forward. The going-off dinner was of course a merry meeting, but tinged as usual with regret at losing our old friends from the Residents' table. Mr. Hammond, H.P., the President, and Mr. M. A.

Collins, H.S., retired, and Messrs. Dobson and Greenfield, H.P.'s, fill their places. The new H.S.'s in place of Messrs. Ticehurst and Collins are Messrs. Blake Odgers and A. C. H. Gray, and on the medical side Messrs. Trubshaw and Pearson succeed Messrs. Clarke and Hammond.

PROBABLY for the first time in the history of Guy's Hospital a summer concert was given in Lazarus ward on Wednesday, 25th ult. The possibility of this was due to the munificence of Mr. Edge, an old patient, who years ago had had his foot amputated by Mr. Birkett. In gratitude for his treatment while a patient here he took this means of expressing his feelings, and also presented the ward with a wheeled couch. The proximity of the Coronation gave a double reason for rejoicing. The ward, which was decorated, but not with the usual recklessness of Christmas, looked particularly well. The patients were regaled with tea and fruit, also provided by Mr. Edge. The programme was very good, and was carried through in a manner which makes individual distinction unnecessary, but among the items that of the Ventriloquist was most appreciated. At the close, after a few words from Mr. M. A. Collins, three cheers were given for Mr. Edge, and the ward was made to resume its natural appearance.

Obituary.

John Wychenford Washbourn.

John Wychenford Washbourn, the second son of the late Mr. William Washbourn, of the Blackfriars, Gloucester, was a member of a family well known in the West of England for some centuries past, his ancestors being the Washbourns of Washbourn and Wychenford, in the county of Worcester. He was born in Gloucester on June 22nd, 1863, and was educated at King's College in that city. On leaving school he entered Guy's Hospital as a science student in October, 1880, becoming a medical student a year later. From the very first his ability was conspicuous, and able though many of his contemporaries were, in those qualities which go to make a successful student he was head and shoulders above them all. Some conception of his powers may be conveyed by a statement of his successes during the years 1881 to 1886. At Guy's he won the Entrance Scholarship in Science, the First, Second and Fourth Year's Prizes, the Michael Harris Prize for Anatomy, the Beaney Prize for Pathology, and the Treasurer's Gold Medals in Surgery and Medicine; while in the wider sphere of the London University he gained the Exhibition and Medal in Organic Chemistry, First Class Honours in Anatomy, the Scholarship and Medal in Medicine, the Medal in Forensic Medicine, First Class Honours in Obstetric Medicine, besides Honours in Materia Medica and Surgery. In Forensic Medicine he had, in the first instance, tied for the first place and Scholarship with Mr. Raymond Johnson, of University College, and it was only after a second examination that the Scholarship was awarded to Mr. Johnson. He graduated M.B., B.S. Lond. in 1886, and M.D. in 1887; he took the F.R.C.S. in 1888 and the M.R.C.P. in 1889, and was elected an F.R.C.P. in 1894.

With such a record it is easy to understand that Washbourn was not kept waiting for any of the Guy's appointments, most of which he held, including Charity and House-Physician. He was dresser to Mr. Howse and Mr. Jacobson.

After becoming qualified he spent a year abroad, chiefly in the study of bacteriology under Prof. Gruber, in Vienna, and Prof. von Baumgarten, in Königsberg. A little later, in order to complete his bacteriological training, he spent some time in Paris and Rome.

Having been appointed Demonstrator of Anatomy in 1888, he was, on the retirement of Dr. Pavy in the summer of 1890, elected as a matter of course to the staff of the hospital as Assistant Physician, and was appointed joint Lecturer on Physiology, Demonstrator of Bacteriology, and Physician in charge of the Electrical Department. Before this time bacteriology had never been taught systematically at Guy's, and Washbourn threw himself heart and soul into carrying out a scheme for providing and equipping a laboratory and organising a department for the pursuit of his favourite branch of pathology. When, a few years later, the Lectureship on Bacteriology was established, he was appointed lecturer.

In 1889 he was elected Assistant Physician, and in 1892 Physician, to the London Fever Hospital. This was an appointment he valued highly, not only because it afforded him excellent opportunities of combining laboratory research with the most suitable clinical experience, but also because of the honour attached to it. For years the London Fever Hospital had been the chief source in England of our knowledge of infectious diseases. On the roll of its staff appear the names of Sir William Jenner, Dr. Murchison and Dr. William Cayley, and to them our friend was no unworthy successor.

In April, 1893, he married Nellie Florence, daughter of the late Mr. William Freeland Card, of Greenwich Hospital School. His short married life was very happy; short, for within a year of his marriage he suffered a cruel blow (perhaps the most cruel a man can

receive), by the death of his wife a few days after the birth of their first child. The child, a daughter, survives him.

Making the most of his opportunities at Guy's and at the Fever Hospital, Washbourn speedily succeeded in building up a firm reputation as a sound general physician and an authority on infectious disorders. His name was perhaps best known in medical and scientific circles in this country and abroad for his work on Fraenkel's Diplococcus Pneumoniæ and on Antipneumococcic Serum; but he published a number of papers, both jointly and alone, on various bacteriological and clinical subjects. One of his best pieces of work was a bacteriological report on the epidemic of typhoid fever at Maidstone in 1897, in which he clearly indicated the source of the contamination of the water supply. In spite of opposing expert evidence his views were accepted as correct by the inspectors of the Local Government Board, who held an enquiry into the epidemic. He also found time to write, with a friend, a "Manual of Infectious Diseases," and to contribute articles to two or three systematic medical works. A few years ago he served on the committee appointed by the Clinical Society to investigate the therapeutic value of the antitoxin of diphtheria, and at the time of his death was one of the secretaries of the Epidemiological Society, and of the Metropolitan Counties Branch of the British Medical Association.

In February, 1890, he was chosen Physician to the Imperial Yeomanry Hospital, then about to be established in South Africa. In this capacity he spent fifteen months, chiefly at Deelfontein and Pretoria, and was rewarded for his services with the C.M.G.

On his return to England in July, 1901, almost his first act was to preside over the section of Pathology at the British Medical Association's meeting in Cheltenham. He was in the best of health, and continued so during the winter, when he published more than one paper on his South African experiences, and busied himself in the preparation of the Croonian Lectures, which he was to have delivered this year before the Royal College of Physicians, taking for his subject acute pneumonia. This work was well advanced when, towards the end of March, he had an attack of his old enemy, influenza; this was followed by pleurisy with effusion. From the first he took a serious view of his own case; though his friends were not without hope when, on May 30th, he left Cavendish Place for the bracing air of Tunbridge Wells. But unfortunately his own suspicions were only too speedily and surely verified. Signs of acute pulmonary tuberculosis appeared and rapidly increased, and he passed away on Friday morning, June 20th, within two days of his thirty-ninth birthday.

So ends the record of the chief events of a life, busy but all too brief. He accomplished much, yet in his case how high "the hope of unaccomplish'd years"! Nevertheless, we believe that this hope will yet be fulfilled in others, in whom the work his enthusiasm created at Guy's will still live and grow.

Washbourn's bent was towards purely scientific research, to which, indeed, he at one time almost entirely devoted himself. But in this country few, even of the greatest ability, find in Science a liberal mistress. His marriage necessitated a modification of his plans, and he was obliged to curtail the time he gave to the laboratory. Tenacity of purpose, impartiality in judgment, thoroughness in method, were present in him if in any man, and these qualities, combined with an irresistible enthusiasm, made him an admirable trainer of research students.

His favourite recreations were skating and lawn tennis. He showed his interest in the latter not only by frequently playing on the courts at Honor Oak Park, but by accepting the vice-presidency of the G.H.L.T.C., and joining with Mr. Lane in presenting a cup to be played for annually by members of the Lawn Tennis Club who were still in "their year."

Of his appearance it would be superfluous to speak in these pages; except to say that he looked much older than his years, and possessed an aspect and manner that at once inspired confidence. His kind, strong personality was one that made itself felt in many directions; so will his loss be the more felt. How great the loss it is too soon to appreciate, too soon even to realise.

Clemence Margaret Cotton.

Clemence Margaret Cotton—Sister Queen—came to Guy's early in 1892 for a year and a half, first as lady pupil, and afterwards for three months as night sister. Those who remember her then know how from the first

she made a mark in the wards where she worked, especially while on night duty, by her extraordinary gentleness and devotion. In 1893 she left the hospital, and went to nurse for a time among the very poor of Plaistow, but in 1895 she returned to us to take up the work to which she has given herself with increasing self-sacrifice for the rest of her life. She was appointed sister of the obstetric ward when it occupied "Dorcas" on the surgical side; and when these patients were moved to the medical building she came with them as Sister Queen. For seven years she worked, though not without protest from those who knew the strain of it, all day, and often half the night, never too tired to give cheerful help to those who needed it, and never making over any of her own work to others, until this last twelfth of June. Then, when all the afternoon operations in Queen were over, she walked down to Clinical private room, underwent herself an operation for biliary calculus the next morning, and died at midnight ten days later.

The long line of those who followed her to the Chapel last Saturday, on her way to her last resting place, showed the regard in which she was held by the whole hospital. Staff, students and nurses, united in grief at her loss. But no words can describe the love borne her by those who have seen her daily life in the ward; and the hospital is the poorer for a quiet example of great goodness.

"——— By such souls alone
God stooping shows sufficient of His light
For us i'the dark to rise by."

Nursing News.

MATRON'S OFFICE.

It is with great regret that we have to announce the death of Sister Queen, Miss Cotton, who died in the hospital on the 24th of June. The first part of the Burial Service was read in the Chapel on Saturday morning at half-past nine, after which the body was conveyed to Liphook and placed in the family vault. The coffin, which was covered with lovely wreaths and crosses, was carried to the Chapel and followed in procession by many members of the Hospital Staff, Sisters, and Nurses. Sister Queen has been connected with the hospital since 1892, was greatly beloved by all who came in contact with her, and by her death Guy's has lost one of its most zealous workers. The good of her patients was her first thought, and her untiring devotion to them, gained for her their love and esteem.

On June 30th Nurse Gibbins, Head Nurse in John ward, and Nurse Spalding, Head Nurse in Patience, left the Hospital on completion of their training. Probationer Russell was appointed to succeed Nurse Spalding as Head Nurse in Patience.

The Barbary Jew.

OF all nations in the world the Jewish is perhaps the most remarkable. A nation which has passed through all the social stages recorded in the Bible and elsewhere, which has then been dispersed in small communities amongst almost all the peoples of the world, and which has yet preserved inviolate its racial purity and its theocratic ideals, is absolutely unique in history. Hardly less curious is the universal and instinctive dislike which is felt for it by all other races.

To anyone who is able to go on wondering at common things, the Jews are never commonplace, and to such fortunate persons even this short account of the Barbary Jew may be of some interest. For he is a kind of epitome of his race. Himself purely Oriental, he lives under the restrictions of the Mediæval Ghetto, and yet has occasional points of contact with modern civilisation.

Morocco is a country in which statistics, or indeed any accurate information of any kind, are quite unknown. The best estimates of the number of Jews in the country vary between two and five millions. In some coast towns there is a Jew to every four or five Moors, but inland—where there is less trade and the treatment to Jews is harsher—they are less numerous. In a very few districts they are entirely absent. There are said to be one or two warlike tribes of pure Jewish descent in the interior, but no one seems as yet to have succeeded in returning with any information about them. The Jews that are known have a double origin. Some of them were found established in the country by the Arab invaders in the seventh century; others took refuge there from Spain in the fourteenth. The first class live chiefly among the Atlas Berbers, and talk Berber and Arabic; the second live on the coast, and talk Arabic and Spanish. There is now no sharp distinction between them.

In the coast towns the Jew enjoys some amount of freedom, and a certain small number have European protection, but inland their position is very clearly defined. For instance, in Marrakesh, the southern capital, they live under the following conditions:—All Jews must live in a certain limited space called the Mellah. The word Mellah means Place of Salt, and is so called because the Jews are compelled to salt the heads of rebels for demonstration purposes, just as they are made to do other things which even a Moor considers filthy. As the Jews are prolific and the Mellah is bounded by a definite high mud wall, the place is grossly overcrowded. The refuse heap, which is also inside the wall, is only distinguished from most of the streets by its mountainous height, while even a medical training is no protection against the streets of the butchers. In this enclosure the whole Jewish population is imprisoned from sunset to sunrise, and even in the daytime any Jew going out into the Moorish town must go barefoot, carrying his shoes in his hand. All Jews are compelled to wear a black gaberdine, a black skull cap, or a blue handkerchief tied under the chin, and black slippers.

They may carry no weapons, in a country where every man goes armed, and may not ride inside the town. Outside they may ride a mule or an ass, never a horse. They may not own slaves or enter the slave market. They may own no land outside the Mellah. They may not give evidence on oath in a law court. In Fez, the other capital, there are many streets, and outside it several towns, which no Jew may enter at all.

The same spirit runs through all their social relations. The mention of a Jew in polite conversation is coupled with an apology, "He was, excuse me, a pig of a Yahoudi." Any Jew at large may practically be robbed or beaten with impunity; inside the Mellah they are safe, for no Mellah has been sacked since 1820; but outside they dare not lift a hand against a Moor on any provocation. In Fez, two years ago (1900) a Jew, who was a naturalised American citizen, dressed in European clothes, was struck by a shareef in the street. Unfortunately, he had lost the habit in America of taking blows meekly, and he retorted with his pistol. He was promptly killed by the bystanders, who were preparing to burn his body, when they were stopped by a Moorish official. The American Government made the Sultan pay compensation, and the Sultan collected the money—plus the usual commission from the shopkeepers of the street. This is the usual method, and saves the expense of a police force.

The result of all this is that the Barbary Jew is a most pitiful creature. Under his greasy black cap falls a long fringe, and at the side two long side curls; he has a white face, and timid, furtive eyes. As he slinks along barefoot, with a bent back, he takes good care to get out of the way of the big black slave from the Soudan, who trots jollily along on his master's donkey, and has all a good Moslem's contempt for a dog of a Jew.

In the country matters are much the same. Accounts of the Jews in the Atlas describe them simply as serfs, owned for all practical purposes by individual Berbers, without whose leave they may not marry or travel, and into whose pockets go the results of their labours. At the same time, for an outsider to kill anyone's Jew is in the nature of an insult, as well as an injury, and in this lies their safety. Even if the matter is arranged amicably the incident costs at least twenty-five shillings, and expense is a great consideration in the Atlas.

I spent an afternoon last May at a country Mellah. The Mellah itself was (comparatively) roomy and clean, enclosed in the usual 10ft. mud wall. Outside were nine or ten little wattled huts, occupied by Moors. The head man, after taking me dove shooting, offered to show me the Jews—much as any other farmer would take one round to see his beasts. The Jews must have outnumbered the Moors by at least ten to one. They were probably most of them far richer, and they lived in solid, square houses. Yet this bare-legged farmer picked up his gun, and took one into their sleeping and living-rooms, even into their Synagogue, made jokes about them to their face, put them through their tricks—weaving and the like—and made them stand up, and get out of the way. The Jews merely cringed and smiled, and sometimes kissed one's coat; they did not even beg, far less resent our presence. After several centuries of this, it is difficult to see how they can ever be taught self-respect again.

The Jews might possess great power, in some ways they do. They have nearly all the trade in their hands, all the usury, and a good deal of the manufactures. They have some good qualities. It is true that they drink when they can, which the Moors do not, but they are more or less moral. Although they marry girls of eight or ten, which is repulsive to our ideas, they are fairly faithful to them, and seldom have more than one wife. They observe their ritual more scrupulously than most European Jews, so that in spite of the filthy state of the market, their "kosher" meat is safer than that which the Moors eat. They keep some oaths, and they are not much more filthy than most Moors when they have room to be clean.

The Alliance Israélite is trying to educate them in some places, rather against their will. But before they are fit for freedom they must unlearn the lessons of centuries of oppression, and only their European countrymen can teach them this. Their greatest hope lies in such a sight as may be seen in the coast towns, a European Jew in a tweed suit and a brown bowler squatting on a carpet with three of his countrymen in gaberdines and skull caps, with long black greasy curls—the 20th century taking a cup of green tea with the 14th.

OWEN RICHARDS.

Medicine and the Motor Car.

THE motor car has come to stay—the cheaper the car the more often it stays. I have not one at present, and should not accept one even as such. What a man tells you casually about his new car is not evidence. If you live opposite a motor car repairer, as I do, you get a much better insight. A medical friend told me some time ago, in answer to sympathetic inquiries, that his car gave him little or no trouble. He did not add that repairs were a source of pleasure to him; that would have given the stamp of truth. My wife says that he is seldom absent from the repairing yard for more than four hours at a time on week days. On Sunday he probably gives the thing a thorough overhauling at home.

The wife of another of my colleagues told my wife last winter that although her husband had a car, he only intending using it as a stand-by; he was not going to get rid of his horses. Since the accident he had, going up a hill two or three months ago, he seems to have used it exclusively in its stand-by capacity. He does nearly all his visiting on his bicycle now, being a great martyr to indigestion, according to his wife. Cycling in wet weather is a potent factor in the production of a healthy pancreatic emulsion. I don't know whether his coachman also suffers from a dilated stomach, but he drives a cab now. It is easy to get him to dilate on the subject

of motor cars, and his remarks are both instructive and free. One of the things he said was: "Motors will never take the place of 'orses. Never! Why? Because they aint got no sense. To give you a hinstance: the other night, two gents what had been to the Chester races drove their car into the governor's yard for the night. They'd had nothing but lemonade and buns all day and yet, before they could stop that thing, it had banged 'em up agin every vehicle standin' in the yard. What with twisted steps and busted splash boards and scraped varnish off our new brougham, I reckon it piled 'em up over five pounds worth of damage in under three minutes. Now, if they'd had a steady old 'orse it 'ud a brought 'em 'ome safe—even if they'd had double that lot of lemonade and buns. No, they's undependable nasty noisy things, as my missus says, as elegant as a mudhopper, as comfortable as a fire engine, and as cheap as a slap up two-'orse brougham."

In that matter of the hill, my friend, the owner of the stand-by, was the victim of the printed instructions he received with his car. As I told him, it was a great mistake on his part to learn them by heart. He naturally repudiates my version of the accident, and only expressed annoyance when I pointed out to him that when a man comes downhill backwards at full speed, and then comes to a full stop through not steering clear of the abutments of a railway bridge, it is reasonable to suppose that his mind is a blank as regards the events crowded into the previous thirty seconds. What really took place was this. He passed safely down the hill and under the bridge and began to mount the other side. Then his car showed that it was intended more as a stand-by than a stayer, for within a few feet of the crest its speed died away. Then followed an agonising moment, during which doubts as to its having stopped must have resolved themselves into certainty that it was moving backwards, and with increasing momentum. It was then that he must have put into use the printed instructions:—"When in descending a hill you find that you are losing your control over the machine, it is better to reverse the gear than to apply the brakes too suddenly, such a proceeding being very prejudicial to the tyres." I believe in his case the tyres were practically uninjured.

When you have mastered your machine sufficiently to drive it at a uniform speed on a straight course, your next difficulty will probably be with the police. A friend of mine was enjoying a spin along the high road the other day when he passed a sprucely dressed young artisan sitting on a stile in a gap in the hedge; he was apparently reading a newspaper, but looked up as he passed. My friend being a wise man promptly reduced his speed to a crawl. If he had been experienced as well as wise he would have turned back and tried some other road. As it was he crawled on with hardly enough steerage way on to avoid being run into by other cars that passed him. He was not altogether surprised to see another young artisan in the hedge a quarter of a mile further on. He was congratulating himself on his acuteness and was just increasing his speed when, on turning a bend in the road, he ran into a posse of police. His name and address were taken, and on the succeeding Thursday he was with several others fined £5 and costs for furious driving, without, as he put it, even getting a run for his money. This particular friend not being a rival practitioner tells me all his experiences, of course on the understanding that it does not filter back to his wife. My remark that I supposed he would enter the fine under the heading *incidental expenses*, led to his telling me of some more. It seems that on the following day he pumped up the tyres before he went to business to save time on his return. When he came back, the day having been unusually hot and sunny, he found that all four had burst. The next time he was able to go out he had a little accident owing to the petrol catching fire but fortunately there was plenty of sand about. Petrol cars are, I believe, especially adapted for sandy districts. Altogether, I think, he made his incidental expenses for one fortnight something over £17 a week.

What a fellow does when he finally gets sick of his motor car has, till lately, been a puzzle to me. Now I find that nearly every farmer within a mile of the high road is grumbling because his shed is occupied by a motor car which was left by tired-looking young men who promised to send in a few days but have not done so as yet.

Having thoroughly studied the natural history of the motor car from beginning to end, I think a little advice to those anxious to indulge in this exhilarating exercise may fittingly conclude my remarks.

Briefly stated it comes to this, if before entering the profession you were thoroughly trained as a mechanical engineer you will probably find a car as cheap as horses, and more congenial to your previously acquired tastes.

If you do not possess this qualification, but are doing well enough in your practice to be able to afford a resident engineer, get a motor car by all means; personally, I should prefer a yacht.

If you do not come under either of the above headings, but are still anxious to have a car, the best plan I know of is this:—

Get a nice roomy cellar, a heavy mangle on castors, and a cyclometer. Rig the cyclometer up on the mangle to give you an idea of the rate you are going at, and then, in your spare time, practice shoving the mangle round and round the cellar without colliding with the walls.

When you can keep this up at three miles an hour without undue perspiration, you may buy your motor car in the full confidence that, if the worst comes to the worst, and you have a breakdown seven miles from home, in a hilly district, you will be able to push your treasure home in safety.

The alternative plan of the farmhouse will come in later on.

To show the wide-reaching effects of the new industry I may instance the case of the little girl who, when her mother upbraided her with neglecting her teeth, said it was because papa had taken her tooth brush for the motor.

F. HEATHERLEY.

Sport.

The Inter-Hospital Sports.

THESE took place on Wednesday, June 25th, in most lovely weather. Unfortunately, we did not do as well as we expected; Bart's. easily winning the shield. Rankine did a very good throw with the hammer, and Lascelles, of St. Mary's, beat his previous record in the high jump.

Morgan had evidently fallen upon an off day as regards sprinting, for after winning his heats in the 100 yds. and 220 yds. on Monday as he liked, he did not succeed in getting placed in the finals. However, he made up for this by winning the long jump. Allen ran well in the quarter, and succeeded in carrying off this event. The attendance was pretty good; but it is a great pity better arrangements cannot be made for the refreshments, which were distinctly poor. Results:—

100 YARDS.

1. W. H. Orton (St. Bart's.).
2. W. J. Gibson (London).

Time, 10⅘ secs.

220 YARDS.

1. W. H. Orton (St. Bart's.).
2. J. St. C. Smith (St. George's).

Time, 24⅕ secs.

QUARTER MILE.

1. R. W. Allen (Guy's).
2. H. F. S. Collier (St. George's).

Time, 54⅕ secs.

HALF MILE.

1. H. E. Graham (St. Bart's.).

ONE MILE.

1. H. E. Graham (St. Bart's.).
2. P. Gosse (St. Bart's.).

HIGH JUMP.

1. J. E. Lascelles (St. Mary's).
2. T. H. Thomas (London).

Height, 5ft. 10in.

LONG JUMP.

1. G. Morgan (Guy's).
2. W. J. Gibson (London).

Distance, 20ft 6in.

HURDLES.

1. W. J. Gibson (London).
2. E. M. Harrison (Guy's).

Time 17⅘ secs.

SHOT.

1. D. M. Stone (St. Bart's.).
2. J. L. Rankine (Guy's).

Distance, 36ft. 10in.

HAMMER.

1. J. L. Rankine (Guy's).
2. G. M. Levick (St. Bart's.).

Distance, 100ft. 3in.

THREE MILES.

1. S. G. Gibb (St. Bart's.).
2. P. Gosse (St. Bart's.).

Time, 15 min. 57 secs.

Cricket.

GUY'S v. M.C.C.

Played at Honor Oak Park on Tuesday, June 13th, and resulted in the Hospital losing by an innings and 72 runs. This is the first time we have secured a fixture with the club and it is a pity the team did so badly, only Willan batting well, his innings under the circumstances being distinctly good. Scores:—

GUY'S.

1st Innings.		2nd Innings.	
H. D. Wyatt, c Davenport, b Smith	1	E. L. Norton, st Davenport, b Johnston	0
H. Barber, b Smith	0	H. Barber, b Earnshaw	0
F. Morres, b Hearne	1	E. Morgan, st Davenport, b Johnston	13
E. Morgan, c & b Hearne	7	H. D. Wyatt, c Nicholls, b Johnston	5
R. Willan, Jun., st Davenport, b Smith	23	E. A. Collins, b Johnston	0
E. L. Norton, c Johnston, b Hearne	0	J. Bookless, st Davenport, b Johnston	3
J. Bookless, lbw., b Hearne	1	F. Morres, b Johnston	1
F. A. Collins, b Hearne	4	L. G. Davies, b Atfield	14
L. G. Davies, b Hearne	0	M. G. Louisson, b Atfield	2
M. G. Louisson, c sub, b Hearne,	5	A. L. Foster not out	5
A. L. Foster, not out	0	R. Willan, Jun., b Johnston	1
Extras	4	Extras	2
Total	46	Total	46

M.C.C.

A. T. Johnston, c Morgan, b Foster	3
A. E. Earnshaw, b Davies	8
C. S. Hanway, lbw., b Wyatt	12
Atfield, b Wyatt	22
Capt. C. V. Isaacke, c Louisson, b Wyatt	2
J. J. Nicholls, (capt.,) c Bookless, b Wyatt	21
W. S. Nealor, c Collins, b Wyatt	35
Hearne (E.G.), c Morgan, b Foster	38
Smith, b Wyatt	0

Davenport, c Louisson, b Foster	2
C. L. M. Cowper, not out	6
Extras	15
Total	164

PAST v. PRESENT.

Played at Honor Oak Park on Saturday, June 21st, and ended in a draw, rain stopping play for more than an hour after Guy's had declared, for the loss of six wickets. For the Past, Alexander and Clarke batted well, and for the Present, Barber and Wyatt added 133 for the first wicket. Scores:—

PRESENT.

H. D. Wyatt, not out	150
H. Barber, lbw., b Wetherell	82
H. M. Langdale, b Wetherell	3
F. Morres, b Wetherell	11
E. L. Norton, b Clarke	20
E. A. Collins, b Cowper	4
E. Morgan, b Clarke	2
J. Bookless, not out	9
Extras	4
Total	285

Innings declared closed.

L. G. Davies, M. G. Louisson, A. L. Foster, did not bat.

PAST.

A. E. Clarke, c Morgan b Wyatt	36
K. B. Alexander, lbw., b Wyatt	24
M. C. Wetherell, not out	4
F. Colclough, b Morgan	3
J. H. Busteed, not out	11
Extras	2
Total	80

E. C. Cohen, F. D. S. Jackson, C. H. Fagge, H. R. Grellet, T. Morgan, C. L. M. Cowper, did not bat.

GUY'S v. HORNSEY.

Played at Hornsey on Tuesday, June 24th, Guy's losing by 2 runs. We had a weak team, Barber and Louisson being away; each side played twelve men and Guy's batted first, Bookless playing a faultless innings of 40 and Morres adding 69 by excellent cricket. For our opponents Barnett hit splendidly and playing at the last moment as twelfth man practically won the match. Score:—

GUY'S.

J. Bookless, run out	40
E. A. Collins, b Hossack	13
E. Morgan b Brewer	19
F. Morres, c Morgan Brown b Duval	69
H. D. Wyatt, b Grimsdell	0
E. L. Norton, c Crinkshank, b Duval	7
A. M. Tolhurst, c King, b Duval	9
A. L. Foster, c Weaver, b Duval	6
L. G. Davies, c King, b Duval	1
J. T. Hicks, st Morgan Brown, b Grimsdale	0
H. H. Carter, not out	1
H. C. Gibson, c Morgan Brown, b Grimsdell	0
Extras	13
Total	178

HORNSEY.

E. E. Barnett, lbw., b Davies	64
W. J. L. Brewe, c Hicks, b Wyatt	18
E. S. Duval, lbw., b Wyatt	7
W. I. Crinkshank, b Wyatt	3
S. L. King, b Davies	29
S. M. Barker, c Foster, b Davies	4
C. I. N. Hossack, b Davies	2
S. T. Weaver, b Morgan	7
H. H. Morgan Brown, not out	0
E. W. Grimsdell, b Morgan	9
W. P. Harrison, b Morgan	2
A. P. Doré, b Davies	4
Extras	31
Total	180

GUY'S 3RD XI. v. CAMBERWELL HOUSE.

Lost after an exciting game by 11 runs. Scores:—

CAMBERWELL HOUSE.

W. Parsons, b Willan	33
Dr. Serjeant, hit wkt., b Willan	20
G. Raymond, not out	51
Dr. Lavers, b Willan	18
C. J. Stringer, b Willan	0
A. L. Michell, lbw., b Morris	18
T. Milton, run out	13
F. Raymond, b Bartlett	2
F. Turner, c Taylor, b Bartlett	0
Shapley b Bartlett	4
G. F. Temple, b Bartlett	0
Extras	50
Total	209

GUY'S 3RD XI.

R. Willan, Jun., c Milton, b Lavers	80
T. R. Harvey, c Temple, b Turner	6
F. Morris, b Shapley	59
G. F. E. Allison, b Shapely	7
H. H. Moyle, c Parson, b Lavers	0
W. H. Miller, c Temple, b Shapley	0
G. N. Bartlett, c&b Lavers	17
H. D. Vernon-Taylor, not out	4
H. O. Brookhouse, b Lavers	4
J. T. Smalley, c Mitchell, b Turner	1
F. A. Sharpe, b Turner,	0
Extras	20
Total	198

GUY'S 3RD XI. v. NEW ELTHAM.

Played at New Eltham and ended in a win by 61 runs —Russell took eight wickets for 23 runs.

GUY'S.

E. N. Fox, c Waite, b Smith	5
T. R. Harvey, c Hobson, b Childs	26
W. H. Miller, lbw., b Childs	10
G. F. E. Allison, c & b Smith	16
H. H. Moyle, b Beale	14
A. D. Vernon Taylor, b Beale	2
G. N. Bartlett, c Waite, b Smith	13
J. T. Smalley, b Smith	0
G. Russell, not out	4
Bastard, b Smith	0
Extras	17
Total	107

NEW ELTHAM.

R. Childs, lbw., b Bartlett	2
T. Hobson, b Russell	0
A. Smith, b Russell	0
W. Waite, b Russell	6
Harris, b Russell	6
B. Blakiston, b Russell	2
W. Warren, run out	9
J. Beale, b Russell	0
G. Richmond, b Russell	5
J. Wilson, b Russell	10
G. Rossell, not out	6
Extras	0
Total	46

Guy's Hospital Lawn Tennis Club.

PAST v. PRESENT.

June 21st, at Honor Oak. This match was scratched owing to the death of our Vice-President, Dr. J. W. Washbourn.

GUY'S v. HAROLD.

Played on Wednesday, June 25th, at Gipsy Hill, and resulted in a win for Harold by 6 events to 2; one event being unfinished.

T. C. Lucas and F. W. M. Palmer v. Ransford and Ransford, 7–9, 6–3, 6–1; v. Vidal and Gamlett, 5–7, 7–9; v. Hanson and Bates, 6–1, 6–2.

B. H. Wedd and E. N. Jupp v. Vidal and Gamlett, 9–7, 4–6, 1–6; v. Ransford and Ransford, 3–6, 1–6; v. Hanson and Bates, 13–11 (retired).

A. Zorab and J. Bookless v. Hanson and Bates, 1–6, 6–4, 9–11; v. Ransford and Ransford, 1–6, 3–6; v. Vidal and Gamlett.

South African Memorial Fund.

THIRTEENTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	230	13	0
C. J. Symonds, M.S.	2	2	0
R. O. Moon, M.B.	1	1	0
W. E. Audland	1	1	0
F. E. Walker	0	10	6
	£235	7	6

Appointments.

CIVIL.

DAKIN, WILLIAM RADFORD, M.D., has been elected an Examiner in Midwifery under the Conjoint Examining Board in England.

MCGAVIN, LAWRIE HUGH, F.R.C.S., has been appointed Surgeon to In-patients at the Seamen's Hospital, with duties at the Branch Hospital in the Royal Albert Dock (to which is attached the London School of Tropical Medicine).

STARLING, ERNEST HENRY, M.D., F.R.S., has been elected an Examiner in Physiology for the Fellowship, Royal College of Surgeons of England.

STEELE, KENNETH, M.R.C.S., L.R.C.P., has been appointed Anæsthetist to the Seamen's Hospital Society, with duties at the Dreadnought Hospital at Greenwich.

TARGETT, JAMES HENRY, M.S., F.R.C.S., has been elected an Examiner in Midwifery under the Conjoint Examining Board in England.

NAVAL.

Surgeon STANLEY S. H. SHANNON, R.N., is appointed to the *Duke of Wellington* for Haslar Hospital.

Births.

EDWARDS.—On June 30th, at 34, Peckham Road, S.E., the wife of Francis H. Edwards, M.D., M.R.C.P., of a son.

FAGGE.—On June 19th, at 22, St. Thomas's Street, the wife of C. H. Fagge, M.S., F.R.C.S., of a daughter.

RYGATE.—On June 12th, the wife of H. B. Rygate, M.B. Durh., of a daughter.

Marriage.

PEDLEY.—USHER.—On the 21st June, at Tunbridge Wells, by the father of the bride, assisted by the Rev. G. W. Cowper Smith, Joseph Kennerley Pedley, L.D.S., youngest son of George Pedley, Esq., of London Bridge Approach, and The Haven, Sutton, Surrey, to Winifred May, eldest daughter of the Rev. W. Usher, M.D., and Mrs. Usher, of Erindale, Tunbridge Wells.

Death.

WASHBOURN.—On June 28th, at Tunbridge Wells, John Wychenford Washbourn, C.M.G., M.D., F.R.C.P., F.R.C.S., aged 38.

ED.—D. G. G.

Contents.

	PAGE
DIABETES: Clinical Lecture by Dr. Hale White	289–298
APPOINTMENTS	298
PASSIM	299–301
OPENING OF THE HENRIETTE RAPHAEL NURSES' HOME	302–304
CORRESPONDENCE: The late Dr. Washbourn; The Hereafter	304–305
THE BIENNIAL DINNER	305–306
NURSING NEWS	306
PASS LIST	306
SOUTH AFRICAN MEMORIAL FUND: 14th Subscription List	306
SPORT: Cricket—Guy's v. Gravesend; Guy's v. Enfie'd; Guy's v. Addiscombe; Guy's 3rd XI. v. Sevenoaks School. Lawn Tennis—The Hospital Challenge Cup; Guy's v. Kent	307–308

Calendar of Coming Events.

July, 1902.

Sat. 19.—Messrs. Symonds and Steward's take-in; Drs. H. B. German and R. Larkin; Cl., C. J. Pinching.
G.H.C.C., I., v. Eltham, away.
III., v. Christchurch Institution "A," away.
G.H.L.T.C., v. Gravesend, home.

Mon. 21.—Exams. for Junior and Senior Prizes for General Proficiency and for the Beaney Prize in Pathology.

Wed. 23.—G.H.L.T.C., v. Brixton Wanderers, home.

Thur. 24.—Messrs. Lucas and Lane's take-in; Drs., C. H. Reinhold and F. Wallace; Cl., C. H. Robertson.

Fri. 25.—School Exams. in Elementary Anatomy and Histology.

Sat. 26.—Summer Session ends.
G.H.L.T.C., v. Harold, home.

Mon. 28.—Test Exam. for Revision Classes for Final L.D.S. Eng. begin.

Tues. 29.—Preliminary Scientific (L.D.S.) Exam.
First Conjoint Exam. begins.

Guy's Hospital Gazette.

JULY 19, 1902.

Diabetes.

CLINICAL LECTURE BY Dr. HALE WHITE.

June 4th, 1902.

(For the shorthand notes of this lecture we are indebted to the Editor of the CLINICAL JOURNAL).

GENTLEMEN,—We have had for some time past a very severe case of Diabetes in Philip Ward, and we now have one in John Ward, and one in Miriam Ward. Mr. Milsom has made some laborious investigations on the urine of the one in Philip, and Mr. Brown is doing the same with regard to the case in John; therefore I thought we should be well employed to-day if we went over some points about diabetes in a clinical lecture.

The fundamental fact about a case of diabetes is that the patient excretes sugar in his urine, and for the case to be one of diabetes the sugar must be dextrose, or, at any rate, very largely dextrose, for Dr. Pavy has shown that there are often traces of other sugars present also, and no doubt that is true; but the fact remains that dextrose is by far the most important of the sugars present. Before we go further into our subject you will remember that you must be careful in testing urine to make sure that you have to deal really with dextrose there. Many people are condemned as having diabetes owing to faulty testing of the urine on the part of the doctor, when the patient really has no diabetes at all. You are aware of the necessity of being careful that your Fehling's solution is fresh; and that is the reason why you boil it before adding urine, because if it is stale a precipitate will occur without the addition of anything at all. But many other bodies beside dextrose may exist in the urine, which will cause a precipitate on the addition of Fehling's solution. For instance, uric acid and creatinin and creatin will all reduce it. But you will always find that the reduction in these cases is not the bright yellowish-red reduction of genuine sugar, but it is the dirty green reduction with which you are all so familiar as occurring in the wards. That does not indicate the presence of sugar. Then sometimes, bodies which reduce the copper solution much better are present in the urine, and yet the case is not one of diabetes, and usually the body which does it is glycuronic acid. Glycuronic acid may be present in the urine after the administration of many drugs. For instance, it may be present after the administration of nitrite of amyl; it may be present after taking chloral, after taking morphia, and sometimes it may be present after taking salicylic acid; and it may also be present after taking chloroform or prussic acid. I have not time now to give you instances, though I easily can, in which every one of the fallacies about

the detection of sugar that I have mentioned has occurred in my own experience. One instance, to show you how sad it may be, I may tell you. I once saw a woman who was being treated with diabetic diet under the impression that she had diabetes with phthisis as a complication. She was really dying of her phthisis, and had been for some time. I could find no sugar in her urine, so I asked the doctor to let me test it with his Fehling's solution. The moment I boiled his solution an abundant yellowish-red precipitate fell, and further testing proved the urine contained no sugar. So this woman for the last two or three months of her life, although dying of phthisis, had been treated with that extremely uninteresting diet to which we condemn diabetics because her urine had been tested with stale Fehling's solution. Another thing you have to remember is that occasionally glycuronic acid will appear in the urine without any drugs being taken at all, and that is another very interesting little side point which we cannot stop to go into to-day. I once saw a patient who had some of the symptoms of diabetes, but she had no sugar in her urine, though she had an abundant quantity of glycuronic acid. You have to remember, also, that sometimes genuine sugar gets into the urine, which is not dextrose. For instance, a suckling woman will pass lactose in her urine, but she has not got diabetes.

However, having mentioned those fallacies, let us narrow ourselves down to the cases in which there is actually dextrose in the urine. But even then we have to subdivide them, and it is doubtful whether all the subdivisions should be regarded as diabetes. One or two things strike any of you who are fresh from physiology. The first is the appearance of dextrose in the urine as the result of damage to the central nervous system. You know that it can be produced experimentally in animals by damage to the floor of the fourth ventricle, and if you tested every specimen of urine passed you would be surprised how frequently it is present in people who are admitted to the hospital suffering from concussion. Dr. Campbell, who is now at Bradford, examined the urine of such patients systematically for some time here, and at some time or another during the first few days of their stay in the hospital after the concussion many of them passed traces of dextrose in the urine. Then, too, we have people in the hospitals with tumours of the brain who pass dextrose in the urine; and, in fact, we have clinically many repetitions of Bernard's experiments of the introduction of glycosuria by damage to the central nervous system. Whether these should be called genuine diabetes is merely a question of nomenclature. Dr. Fagge was of opinion that they were better not called so, and I think so too. I think it is better to call them cases of nervous glycosuria, because probably the glycosuria is of far less importance to the patient than that of genuine diabetes. In the first place, clinically it is unimportant because, as a rule, it passes away in a few days, just as experimental glycosuria by damage to the central nervous system passes away. At any rate, it is so rare for a case of glycosuria due to nerve lesion to be of clinical importance from the point of view of glycosuria, that I think we need not stop to say anything more about it. The probable pathological explanation of it is that there is only the hurrying on into the circulation of sugar which ought to have been stored up.

The next group about which there is some doubt as to whether they should be called diabetes are the so-called gouty or alimentary glycosuria cases. This form occurs in old people, and it is very important for you to bear in mind as clinical men that nobody wears out in a particular part of the body to the same extent as another. Some of us begin to wear out early as regards our hair, and some of us do and some do not wear out early with regard to our teeth. Others do not wear out with regard to their heart until perhaps eighty or ninety years of age. Elderly people sometimes seem to wear out as regards their power of storing up of sugar, and late in life, at the age of about fifty or sixty, they pass straight into their blood ingested sugar instead of storing it up, as you and I do. This alimentary glycosuria is solely a failure of the body to utilise ingested sugar. It passes into the blood and so into the urine. And this sugar is purely dextrose, and in these people the copper reducing test, the yeast fermentation test, and the polarimeter all show analogous results in the

estimation of the sugar, showing you are dealing with a single body and not, as I shall show you presently when talking of diabetes, with many abnormal bodies in the urine. These people do not give what we will come to presently, a ferric-chloride reaction; they have not excessive acidity of their blood, and they can, generally speaking, and, indeed, almost always, be cured by so adjusting their diet that they neither pass sugar in their urine nor lose weight. Often these patients are overdieted, and too much carbohydrate is taken out of the food, so that they lose weight in consequence. We only need to see that they do not pass sugar in the urine, and that they do not lose weight. Probably the fundamental differentiation of these two groups, namely the nervous glycosuria and the alimentary glycosuria, from genuine diabetes consists in the fact that in neither of the first two is there any hyperacidity of the blood, but in genuine diabetes there always is, at some period or another of the illness.

I want you to consider for one moment the nomenclature. I think men get confused about this. The disease which we are now about to describe, diabetes with hyperacidity of the blood, must be separated off, certainly clinically and perhaps certainly pathologically, from the nervous and alimentary forms. Dr. Pavy prefers to call the form that we are going to describe "composite diabetes," for a reason I will tell you directly. Dr. Fagge thinks that the alimentary and the nervous forms should be called glycosuria, reserving the name diabetes for the other form. I should mention here that occasionally the alimentary glycosuria cases become genuine diabetes later on.

Now with regard to true diabetes. But before beginning that, please to remember you must separate sharply diabetes from the experimental glycosuria which can be produced in animals—and in the man too for that matter—by the administration of phloretin and phloridzin. When either of these is administered there is no excess of sugar in the blood, for their action is on the kidney. In every case of genuine diabetes there is an excess of dextrose in the blood. Where does this excess of dextrose in the blood come from? It is obvious it may come from over-production in the body of dextrose, or it may come from failure on the part of the body to utilize dextrose ingested. Which of these is true it is very difficult to settle authoritatively and finally; but most people who have thought much about the subject agree that in the main the pathology of diabetes is to be sought in the fact that for some reason the body fails to utilize dextrose as it should. But although it is true that some of the sugar—and I believe by far the greatest part—in the urine in diabetes is due to the fact that the body fails to properly utilize sugar, that cannot be quite the whole of the explanation, because, as you can prove in the wards, if you have a severe case of diabetes you may cut out absolutely for several days all carbohydrates from the food and yet the patient will continue to pass dextrose in his urine. And then, to show you how very complicated the problem is, I am always pointing out to you the remarkable fact which Dr. Pavy first pointed out, that you may sometimes add very little sugar to the diet and that will lead to an enormous quantity of sugar in the urine. One of his classical cases was that of a man who was on strict diet and took a pint of cider. For a long time after he took this pint of cider the sugar in his urine was enormously increased. There was a girl in the hospital under me whose quantity of sugar passed shot up and kept up a long time, and then we discovered that the only error in the diet was that she had once taken a little marmalade with her breakfast. Therefore we see that while the prevailing, and probably the correct, opinion as to the pathology is that the body fails properly to utilise sugar, and hence it exists in the urine nevertheless that cannot be the whole explanation; there must in some cases at any rate be an increased production of sugar. And Dr. Pavy believes, and you will see there is a very good reason for the belief, that the extra sugar comes from the proteid tissues of the body. They abnormally break down in such a way as to lead to the production of sugar, and it is because these cases of genuine diabetes have two sources for their sugar, namely the failure to utilise that which is ingested, and also some produced which ought not to be produced, that Dr. Pavy prefers to call them instances of "composite diabetes," thus

indicating two sources of sugar. I think that is an excellent name. Before leaving that, please notice again the pathological importance of the fact that giving a little sugar may lead to a hundredfold amount of sugar appearing for days afterwards in the urine. That makes one stop to think, and shows, as Dr. Fagge pointed out years ago, that in a bad case of diabetes sugar is a downright poison.

Now to come to another part of the subject, the fundamental point of which is that the patient is passing out of his system by means of the urine a quantity of sugar, and as a result of that he is losing a lot of energy. If a man passes, as a bad diabetic case will pass, half a pound of sugar a day, he is losing what energy he might otherwise have derived from the breaking down of that sugar. To show that that is so I have copied out from von Noorden's classic book on the subject the figures from one of the patients. You will see how important this loss of energy by means of the urine is. Mrs. B— weighed 55 kilos., therefore her needs were $55 \times 35 = 1925$ calories. She took daily in the form of albumen 148 grammes, her albumen was worth to her 606·8 calories; she took 102 grammes of fat, and her fat was worth 948·6 calories; and she took 180 grammes of carbo-hydrates, which were worth 738 calories, making a total in all her food of 2293·4 calories. You may say she is having enough, because she only requires 1925, and she is taking 2293. But she excretes 141 grammes of sugar every day, the caloric value of which is 678 calories. Thus she was losing this quantity of energy per day. Her food was worth 2293, and she was losing in her urine 578, so she was only really getting from her food 1715 calories a day, whereas she required 1925. Thus she was short every day by 210 calories of energy. That shows you why it is so important pathologically to the patient, this loss of sugar in the urine. It is a dead loss of energy. But this failure on the part of the patients to utilise their dextrose, leading to this great loss of energy is a very subtle problem, and we have not yet got to the bottom of it. And I want you to think, in connection with it, of the following facts. In the first place, they can utilise levulose. Then there is the fact I mentioned of a little sugar leading to a large amount of sugar passed by the urine. That is difficult to understand. Another thing is, although we know that the body, for some reason or another, cannot utilize the dextrose and oxidise and break it down, yet the failure of the body generally to oxidise is not gone; it can use fats; lactates in a diabetic are oxidised to carbonates, and benzol is oxidised to phenol. Another thing is that people who are asphyxiated and therefore cannot oxygenise well, do not, as a rule, get diabetes. Therefore, this failure to break down the sugar is evidently a very difficult failure to properly understand, and it has been suggested that what is really the matter, pathologically, with these people is not that they fail to break down the sugar through all its steps down to its lowest breaking down, but that they fail only in one particular step; but what that step may be we do not know. You will say is all this of any clinical value? Yes it is, because now that I have been able to put before you some of the pathological facts, they will enable you to explain many of the symptoms.

In the first place, we can explain the polyuria, the increased amount of urine passed; more water is passed to get rid of the sugar. Even as it is, with the polyuria the specific gravity is up to 1030 or 1040. This high specific gravity is explained by the presence of the sugar. And in passing let me remind you that we are often confronted with a patient in whom the sugar containing urine has a low specific gravity, and that is often due to the fact that such patients are subject to chronic Bright's disease as well as diabetes. The specific gravity of their urine, because of the Bright's disease, would, perhaps, be 1008 or 1005, but the sugar in the urine brings up that specific gravity to 1016 perhaps. So a low specific gravity with sugar in the urine should always excite apprehension, and is usually indicative of a bad prognosis. Remember that the presence of glycuronic acid does not give a high specific gravity in the urine. The wasting is clearly explicable from what I have told you. If the patient is losing every day, say, 210 calories, the energy which is short owing to excretion of sugar in the urine, the body tends to make it up from

other tissues, and hence fat disappears and the muscles waste, because of this effort to make up the requisite quantity of calories from other tissues. You have also to remember that some of the sugar which passes out in the patients' urine ought to go to build up their fat and their proteids; so you see that they do not get that source for building up fat and proteids; and this accounts for some, but probably a small part, of the wasting. The breaking down a quantity of fat and proteid in their body to compensate for the loss of energy in the urine, leads to the explanation of another symptom, namely, that these patients pass an excess of urea, because of the excessive breaking down of the proteid, which is to compensate for the loss of energy in the sugar passed in the urine. Another symptom follows from what I have told you, namely, their weakness. Another symptom is pruritus, which is often troublesome, especially about the vulva. There is sugar in the urine, and some hangs about the vulva and prepuce in uncleanly people; it remains there and ferments, and the irritation sets up the pruritus. Then, inasmuch as these people are so much below par and wasted, they are an easy prey to all sorts of infections. Diabetics bear any septic process extremely badly; they are very liable to carbuncles and boils, and are especially liable to the invasion of tubercle bacilli. That concludes the sugar part of the question.

But I have not explained, after all, the most important symptom, namely, the coma. In all marked cases of coma you will find the acidity of the blood to be increased. It was increased both in the case which Mr. Milsom looked after, and in the case which Mr. Brown has looked after, and I shall show you before we have finished the reasons for supposing that this increased acidity is the cause of the coma. The increased acidity is due, most people believe, to β oxybutyric acid, which is in excess in the blood in cases of diabetes; other substances which contribute to the increased acidity are diacetic acid and amido-acetic acid. Acetone is also present. All this is of very great importance, because we believe that the acidity is the cause of the coma. These abnormal substances are passed in the urine, but most of them are difficult to detect there, and hence the importance of the ferric-chloride reaction. It is believed that the diacetic acid in the urine causes the urine to assume that dark red wine colour with ferric chloride which you all know from testing in the wards. You must add enough ferric chloride to re-dissolve any precipitated phosphates. There is no other ready test for determining whether these abnormal acids I have told you of are present, and hence it is a simple and a ready test of the very greatest practical value if, as we believe to be true, the presence of these acids means that the patient is liable to have coma. If there is no ferric-chloride reaction present it is not a bad case; if there is marked ferric-chloride reaction it is usually a bad case, because the patient has got an excess of acids, and we believe that these acids are the cause of the coma, and hence such a patient is always liable to coma. A bad case may pass 20 to 30 grammes of oxybutyric acid in a day. Think what that means. The normal alkalies of the blood are the sodium phosphate and the sodium carbonate. Suppose there is a sudden flooding of the blood with acid, there is not enough sodium phosphate and sodium carbonate to unite with this excess of acid, so a fresh draw is made upon the body, and that draw always takes place first upon the ammonia, and a quantity of ammonia goes into the blood to unite with this excess of acid, and in a very bad case calcium and magnesium are also called forth from the tissues into the blood to neutralise the excess of acid there. And this excess of ammonia, of calcium and magnesium, is passed in the urine, and hence it follows that if we estimate the amount of ammonia and calcium and magnesium in the urine, we have a rough estimation of the excess of the acidity. The amount of ammonia per day passed normally is rather over a gramme, but in a case of diabetes you will often find it is considerably in excess. Mr. Milsom and Mr. Brown have analysed the urine in both the cases of diabetes which we have now in the hospital, and in both of them the ammonia was considerably in excess—in Mr. Brown's case it is 6 grammes, and in Mr. Milsom's 2·6. That, therefore, shows that the acidity of the blood was considerably increased,

and we infer from that there is a great excess of these acids present in the blood.

Another way of getting at this question of whether there is an excess of acids in the urine and, therefore, in the blood, is this: you distil the urine with strong sulphuric acid, and you can recover the crotonic acid, this coming from the oxybutyric acid. Mr. Milsom and Mr. Brown have both done this, and the urine in each case shows a large amount of crotonic acid. This is confirmatory evidence that these patients have a large excess of β oxybutyric acid in their urine. Another way, which is employed by Dr. Pavy, is the following:—Dextrose is a right-handed body when estimated with the polarimeter, and β oxybutyric acid is a left-handed body. If you first ferment off the dextrose from the urine, and get rid of the sugar from it, and then see how much left-handed it is, the degree of left-handed rotation is approximately equal to the quantity of β oxybutyric acid present. I have copied here from an analysis of urine in a case given by Herter the amount of bases present. You will see how in diabetes a large amount of bases is present to unite with the excess of acid in the urine. The bases in the urine in a healthy person were as follow, in grammes:—K_2O, 0·9232; Na_2O, 3·881; CaO, 0·2154; MgO, 0·0806; NH_4, 0·4707 (giving a total of 5·5709 grammes). In the diabetic they were as follow:—K_2O, 2·554; Na_2O, 2·445; CaO, 0·083; MgO, 0·1973; NH_4, 3·1130 (notice the very large figure which ammonium reaches in the diabetic, and also the very much larger total of 9·1128 grammes).

You will say what is the proof that this acidity has anything to do with the coma? Well, we went a long way towards proof in the cases forming the subject of this lecture. Theoretically, it should be a good thing to give diabetics alkalies, and when people begin to get symptoms of coma the administration of alkalies is good; but they must be given in large amounts to be efficacious for the patient. In Philip Ward the patient was given 300 grains of bicarbonate of sodium a day, and by that means we were able to neutralise the excess of acid, and I think those of you who watched the case had little doubt that the bicarbonate of sodium saved his life. The woman in Miriam, too, was very much improved by it, so much, indeed, that we hoped she was going to recover. Not only did we diminish the coma, but we saved the call upon the tissues of these patients for ammonium, calcium, and magnesium with which to neutralise the acids in the blood. And this diminution of coma, on giving alkalies, is evidence that the coma is due to acidity. Another reason for believing that acids are the cause of coma is that Sternberg and Grube claim to have shown that by injecting diacetic acid into animals, symptoms very closely akin to those of diabetic coma can be produced. If what I have been telling you is true, another fact is explained, namely, that coma is so often preceded by gastro-intestinal disturbance, especially abdominal pain, vomiting, and constipation. Probably the reason is that one channel, namely, the bowels, is no longer active, owing to the constipation, and so some acid which might have been got rid of by the bowel is retained, and hence the patient becomes comatose. At any rate, this clinical fact remains, that it is very bad treatment to allow a diabetic patient to become constipated.

How the acid causes coma I do not know, but the following suggestion has been made. The sodium in the blood naturally helps to carry the carbonic acid from the tissues to the lungs. If the sodium salts are taken up with this excessive acid in the blood the carbonic acid cannot be carried from the tissues to the lungs; and it has been suggested that this causes the coma. That does not in any way affect the quantity of oxygen in the blood, and that is why a person with diabetic coma is never livid; it is simply an inability to carry the carbonic acid from the tissues to the lung. Very few gas analyses have been made in such cases, but in the few which have been made the investigations have confirmed the fact that there is a deficiency in carbonic acid in the venous blood. The source of these excessive acids is almost certainly in the proteid tissues, and it is the abnormal breakdown of proteid tissues that leads to their presence in the blood and hence in the urine.

Now we have considered two metabolic processes. And there is a third which rarely occurs,

and about which I can tell you little; but I may only mention it to-day because it was so beautifully shown in the patient in Philip Ward. That is, that there is sometimes in the blood a curious condition which is sometimes due to fat. Many of us saw the blood of the patient in Philip Ward whom we venesected on two occasions, a clot separated from the blood which I cannot compare in colour to anything better than to strawberries and cream. That has been observed in cases before, but it is not a common phenomenon. Of the mode of production of this curious condition of blood we are very ignorant. It is usually said to be due to fat, but we could not obtain any evidence of fat with osmic acid, although under the microscope we saw a number of granules which were quite uninfluenced by osmic acid. I sent the blood up to Cambridge, where Mr. Cole analysed it for me, and I have his analysis here. He reports that the blood does not, in the ordinary acceptation of the term, contain fat, because he says, "I find that the white substance is insoluble in water and salines, and more or less soluble in alkalies. It seems to be a proteid precipitated out by the presence of a fatty substance; but what the proteid was I was not able to discover. The fatty substance is not a true fat, but is apparently an ester of cholesterin with one of the higher fatty acids, or a mixture of them." So that is very interesting as showing that sometimes at any rate this fatty-looking stuff, looking like strawberries and cream, in the blood, is not due to fat in the ordinary sense of the word, and that it does not stain with osmic acid like ordinary fat does. I have looked in many books, and I find the statement copied from book to book, that fat may be found in the blood of diabetics, but I have come across a case recorded in the "Edinburgh Medical Journal" of July, 1879, by Saunders and Hamilton, which bears much upon ours. In it there was just the same condition as we saw in the blood of our patient. But the authors say that in that case not only were fat globules present which would stain with osmic acid, but also there was a granular precipitate to be seen under the microscope which would not stain. And that suggests that in our case we had the granular precipitate which Mr. Cole analysed with the result I have read out to you, but we did not have the fat globules. There is no doubt, I think, that in the case recorded by Saunders and Hamilton, fat was there, because the patient died and sections were cut, and the capillaries and vessels were found to be full of fat globules which stained with osmic acid, and there are chromo-lithographic plates in the paper showing this. But I am able to tell you nothing as to how it comes about that this condition appears in diabetes. So extreme was it in our case that we saw a strawberry-and-cream fluid circulating in the retinal arteries and veins, producing a condition the like of which I have never seen before. I had a water-colour drawing, which I show you, made of the retina, but it is not quite a faithful representation, because the artist has depicted the blood as rather too yellow.

You will, perhaps, ask me, are there any post-mortem appearances characteristic of diabetes? In a certain number of cases the pancreas is found diseased. Here are figures from Guy's which will interest you on the point. During fourteen years here we had 6708 post-mortems, and among those post-mortems the pancreas was diseased in 142, that is to say, 2 per cent. In nineteen of those 142 cases the diseased pancreas was associated with diabetes. In sixteen of those nineteen the pancreas was small and atrophic, in one there were pancreatic calculi which had led to atrophy of the gland, and in one there was a large pancreatic cyst, and in the last the pancreas was very large and indurated. So there is quite a considerable number of cases of pancreatic disease associated with diabetes, and as everybody else who has worked at the subject has found out, far the most common pancreatic condition to get with diabetes is a small, hard, fibrous, atrophic pancreas. It is easy for you to remember that this condition is to the pancreas what contracted granular kidney is to the kidney. I took the number of fatal cases of diabetes during the same fourteen years that I took these cases of pancreatic disease, and I found we had four times as many fatal cases of diabetes as we had cases of diabetes which showed pancreatic disease. So we get a definite disease of the

pancreas visible to the naked eye in a quarter of our fatal cases of diabetes. But that figure is, in all probability, far too low, because in every case only the naked-eye appearance is recorded. Another point of view, as showing the importance of the pancreas, is that there were only three cases showing the small atrophic pancreas in which diabetes was not present, and in one of them the atrophy of the pancreas was due to pressure of a large mass of growth, and in another the patient was very wasted indeed, so that the wasting of the pancreas might have been part of the general wasting. In the third, a woman who died soon after admission, no examination of the urine was made, so she might have had diabetes for all we know. These figures are confirmed by those in Berlin. Hausemann, analysing the figures from the Berlin Pathological Institute for ten years, found diabetes without pancreatic disease eight times, with no mention six times, with disease of pancreas forty times, again showing the importance of the pancreas. And of these forty cases thirty-six were examples of simple atrophy, thus confirming our results, three were called fibrous induration, and one "a complicated case." The pancreatic diseases which Oser, writing in Nothnägels "Encyclopædia," mentions as associated with diabetes—you will remember we saw atrophic pancreas, pancreatic calculi, and a cyst associated—are fatty degeneration, indurative pancreatitis, pancreatic calculi, carcinoma, cyst, hæmorrhage, necrosis, and fat necrosis. So I think you will agree that clinically there is no doubt that disease of the pancreas is frequently associated with diabetes. It is not due to any want of secretion of the pancreas being poured into the intestine, because it does not follow in animals in which the pancreatic duct is ligatured, nor is the diabetes due to any disease of the nerves in the neighbourhood, for it does not follow in animals if you transplant pancreas from its normal situation to under the skin. It has been suggested that there is an internal secretion poured from the pancreas which is constantly preventing glycosuria in the normal individual, and that is a view taken by Tuckett in a paper in the "Journal of Physiology," in which he suggests there is constantly being absorbed by the intestinal lacteals a body which is tending to make us all diabetic, but that the internal secretion of the pancreas is constantly antagonising this. The other obvious view is that the internal secretion of the pancreas in some way aids the complete breaking down of the sugar, so that when this internal secretion is deficient we get diabetes. Nobody knows which view is true. Before leaving this part of the subject I ought to remind you that it has been suggested that the essential parts of the pancreas that have to do with the internal secretion, the alteration of which causes diabetes, are the islands of Langerhans.

I have told you the principal facts about the pathology of the disease, and shown you how the symptoms are associated with it. And now for two or three minutes I will speak about the treatment. With regard to the treatment, I have told you about the alimentary form of glycosuria. There you have to reduce carbohydrates in the patient's food so that he will not pass sugar in his urine. You must not cut down the carbo-hydrates too much, or else he will lose weight. You have to find that point in the diet in which sugar will not appear in the urine, and yet the patient will not lose weight. You may say why stop the sugar if all that is the matter is that he takes in too much and passes too much out? Clinical experience is quite clear as to the advantage of such a course, and the reason of the advantage is probably that as it is an abnormal thing for the body to have to get rid of sugar in the urine, it upsets the balance of the patient's economy. And these patients are sometimes, but not always, obviously out of sorts when they pass sugar in their urine, and they are better when you stop it; they are not seriously ill like the composite diabetic cases, because the sugar is often quite accidentally discovered, and it may be so slight as not to necessitate any particular diet for it.

Now we will pass on to the treatment of the severe form. You might think that as the patients lose a lot of sugar it would not be bad to give them a lot of it. But you must bear in mind that, as just mentioned, it is probably a great strain upon the body to pass a lot of sugar.

in the urine, because it is an altogether abnormal process to get rid of a quantity of sugar. We are not built to get rid of a quantity of sugar in our urine, and you would not be giving the patient anything he could utilise if you gave him more, and you would be enormously increasing the strain on his tissues to get rid of the excessive amount which you gave him, and, further, we have seen that there is strong evidence that in diabetes carbo-hydrates may be an actual poison. We have learnt by clinical experience that these patients are very much better if you diminish the amount of carbo-hydrates in the food. But you have to remember this, that all diabetics can probably utilise some sugar, especially levulose, and the mistake is often made of cutting down the sugar too much. It is necessary for the doctor to feel his way, and to find the amount, particularly of levulose, which you can allow each patient. And while the patient is at the same time gaining weight and feeling stronger the excretion of sugar is lessening, and the ferric-chloride reaction of the urine is diminishing, the patient is gaining ground whatever diet he is on. You must remember that you cannot prescribe a uniform diet directly you see the patient. You have to find out in the case of each individual what you can allow in the way of carbo-hydrates, bearing in mind you want to keep up his strength and weight, prevent coma, and diminish the ferric-chloride reaction in the urine. It is only by frequent examination and much discretion you can decide in each case how much, if any, carbo-hydrates you can allow.

But there are also several other practical hints which I want to direct your attention to. Every one is agreed that you can be too strict, and that many patients lose weight because the doctor does not allow them that small amount of carbo-hydrates, especially levulose, which they can utilise. I have already pointed out the importance of the fact, however, that a slight increase in the amount of sugar may lead to a great increase in the sugar passed in the urine. You must particularly remember that, although diminishing the ingested carbo-hydrates leads to a diminution of acids in the urine, and also to a reduction in the ferric-chloride reaction; yet suddenly taking all of them out of food may sometimes produce coma. Therefore you might say, "Is not it good, therefore, if the patient is comatose, to give sugar?" It has been tried, and I have tried it myself, but no good result has followed. Nor is it any good to give pancreas to diabetics. We have tried it and it is useless. Another little thing which I want to point out to you is that there is a very common and serious error met with frequently, and that is that diabetics can take toast with impunity. I cannot trace that falsehood—for that is what it is —to its originator, and I do not know who started the notion that after toasting bread it is no longer a carbo-hydrate, but it is very widely spread among people that a diabetic can take toast. There is no justification for it, and until you can toast bread so that you can make it no longer a carbo-hydrate the diabetic must not have it. I would recommend you, before you give diabetic foods, to occasionally pour some iodine on samples of them. Some manufacturers of diabetic foods, like some manufacturers of other articles, frequently adulterate the foods. I have actually had specimen foods sent to me containing much starch. Another point in the treatment of diabetes is that fats are particularly useful. Many a diabetic is given too much meat and not enough fats. They bear fats very much better than anything. I need not go over the various foods which are given in these cases. The substitutes for bread which contain little carbo-hydrate are gluten bread, soya beans, cocoa-nut flour, almond flour, plasmon, and these are those frequently met with in England; abroad, rice albumen, wheat albumen, and milk albumen are used. The cheapest of all these is cocoa-nut, and the poor can buy cocoa-nut in large quantity, grind it, convert it into powder, and make cakes of it at home. If you wish to give levulose, that can be given as such. We tried a few years ago giving dahlia tubers, as the starch in them is inulin and is converted into levulose. Their use was only fairly satisfactory, as they were difficult to cook nicely. If you wish to give milk without its carbo-hydrate you can mix cream with albumen water, and add saccharin to taste, as was recommended by Williamson. For some reason which we do not understand,

few things are worse for a diabetic than worry. Many a time coma has been brought on by the excitement of a journey, or by some nervous worry, or something of that sort. Every diabetic should be placed in a condition of quiet and content. The question is often asked whether such patients should go to a health resort. There is no evidence that the composite diabetic benefits by such a change. The people who do improve at health resorts are those who are suffering from alimentary glycosuria. These people have their bowels kept open at such establishments, and some of the sugar is kept out of their foods, and they get on very well.

With regard to drugs, they are of secondary importance compared with diet. Opium and codeine can restrain the passage of sugar in the urine, and it is very striking, and must have struck you all, that although the diabetic person is particularly liable to coma, he bears opium well. Probably the next best drugs to opium for restaining the sugar in the urine are the salicylates.

If the coma is only a little drowsiness, dissolve 300 grains of bicarbonate of sodium in a pint or two of milk and let that be drunk during the twenty-four hours. If coma is well marked, transfuse a solution of bicarbonate of sodium into the cellular tissue of the breast or axilla, or throw it up the rectum; the patient ought to get, in a severe case, 500 grains of sodium bicarbonate in a day.

The prognosis must be very quickly summed up. You cannot give a prognosis in any case until you have seen the effect of treatment. The prognosis depends on how quickly you can get the sugar which is in the urine under control, how quickly you can get the weight increased, and how quickly you can get rid of the ferric-chloride reaction. You know that frequent coma is bad, that young subjects do badly, and you know, too, that people who get phthisis, or any complication, do badly. With regard to the question What makes the pancreas diseased when it is affected? we know nothing of that. There is slight evidence that the disease is hereditary, but it is not very much so; and it is not known to be transmitted directly from the mother to the fœtus. The fœtal urine in a case where the mother is diabetic does not contain sugar, but the liquor amnii does.

We have only been able to touch on the fringe of many branches of this fascinating subject, but I trust I have told you enough to interest you in it, but as I have already exceeded my time I must now say no more.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. G. E. Malcomson (Dr. Taylor); G. Evans (Dr. Hale White); H. Tipping (Dr. Pitt): B. Glendining (Dr. Perry).

Ophthalmic Dressers.—Messrs. D. H. Trail, M. A. Collins (Mr. Higgens, August 1st); M. C. Wetherell, L. S. H. Glanville (Mr. Brailey, August 1st); S. L. Pallant, T. C. Lucas (Mr. Higgens, September 16th); C. H. Dawe, H. M. Goldstein (Mr. Brailey, September 16th).

Surgeons' Dressers.—Messrs. C. H. Reinhold, F. H. Wallace, H. Mann, C. D. Pye-Smith, G. Carlisle, W. T. P. Meade-King (Mr. Lucas); R. Moyle, P. R. Bolus, G. F. Hardy, M. B. Taylor, H. O. M. Beadnell, C. E. Iredell (Mr. Golding-Bird); H. D. Smart, E. L. Ward, J. W. Dadd, F. P. Hughes, S. C. Bowle, F. G. Goble (Mr. Jacobson); H. B. German, P. A. Peall, K. Black, B. W. Lacey, E. H. B. Milsom, C. S. Morris (Mr. Symonds).

Dental Surgeons' Dressers.—Messrs. F. H. Parker (August–September); G. B. F. Churchill (September–October); E. H. Griffin (October–November).

Assistant Demonstrators in Anatomy.—Messrs. A. B. O'Brien, A. G. Jones.

Assistant Demonstrators in Chemistry.—Messrs. E. W. Giesen, W. H. Miller.

Externs.—Messrs. T. C. Lucas, D. H. Richards, D. R. Pike, H. C. Winckworth, C. E. Adams, H. E. Morris (August); A. Croneen, J. T. Hicks, A. R. Brailey, N. I. Spriggs, H. Ackroyd, R. Larkin (September); F. C. Robinson, R. Willan, W. H. Bush, J. S. Cooper, J. H. Donnell, E. N. Jupp (October).

CIVIL.

LISTER, THOMAS D., M.D., M.R.C.P. Lond., has been appointed Assistant Physician to the Mount Vernon Hospital for Consumption and Diseases of the Chest, Hampstead and Northwood.

Papers by Guy's Men.

Some Effects of the Ligature of the Renal Arteries in the Frog. By A. P. Beddard, M.D. Camb., M.R.C.P Lond.—*Journal of Physiology*, No. 1, vol. xxviii.

Passim.

Amongst the numerous gala days which stand as beacons in the fairway of Guy's progress, that on which the Prince and Princess of Wales came down to open the Henriette Raphael Nurses' Home will hold a prominent place. On that day the Prince made his first official visit to our hospital since he became President, and gave a very practical demonstration of the interest which he takes in its welfare by the ready graciousness and thorough-hearted manner in which he devoted his afternoon to our benefit. On that day also the very object of his visit marked one of the greatest steps in our advance since the foundation of the Students' Club and College. Mr. Cosmo Bonsor's speech, which is elsewhere reported in this number, touches upon the pressing and growing necessity for the proper housing of our nurses which has been so long felt by the hospital authorities, and which is now obviated by the generosity of Mr. Raphael. A more than local, in fact a national importance was attached to the occasion by the introduction into the Prince's clear and eloquent speech of a return of thanks on behalf of the Royal Family to the British Empire, for the sympathy which the latter had evinced during the unfortunate, but happily-terminated illness of its beloved Sovereign.

The day itself was perfect, and the park and colonnade were resplendent with the summer dresses of the ladies and the variegated robes of the doctors. Things we have never seen before sprang to life and changed the aspect of the park beyond recognition. The fountain became filled with water-lilies and gold fish; the centre tent which held the Prince's audience was converted into a bower of beauty by exquisite masses of flowers and hanging fernery. Indeed, the arrangement and beauty of the flowers was one of the most effective and successful factors in the production of a most successful afternoon.

Neither a comic nor a tragic incident was wanting to complete the day. The comedy was supplied by the Lord Mayor's well-known coachman, who so impressed the porter at the gate that he was allowed to sweep round into the courtyard reserved for the royal carriage only. Hats flew off, and a solitary figure dashed off to the park with the news of the arrival. And then the Lord Mayor stepped out with his genial face, and heartily welcome as he was, it was difficult for many to repress the smile which mingled with the greeting. The tragedy was supplied by an avalanche in the shape of a not unknown hospital servant, who crashed through the skylight of the Eye Wards upon the astonished patients below, with fortunately no very serious damage to anyone. The only really unhappy creature whom we noted was the unfortunate little gold fish who had been promoted to the upper regions in the fountain, and who spent the afternoon and evening in fruitless endeavours to emulate the achievements of Captain Webb and swim over its little Niagara to his friends below. A detailed account of the speeches will be found elsewhere.

Unfortunately the days of touching for the King's Evil are gone and accordingly the usual heavy Monday casualty and out-patient list had to be dealt with by the usual officers. It was obviously impossible that the doubly-policed stretcher and the marasmic infant should be allowed to mingle with the royal and civic dignity in the front quadrangle. The front gates were closed at half-past eleven o'clock and thenceforth all casualty cases were treated "down at the back." Naturally enough, what with the usual Monday load and the pocket ailments which were drawn to the hospital on the off chance of a peep at royalty, the work was heavy, but everyone concerned buckled-to loyally, and despite the attractive strains of band and the contagion of cheering, stuck to duty till the end. A small thing, perhaps, and hardly worthy of note. Yet in common justice to those concerned we offer them an official pat on the back.

When the last faint cheer in the distance had signalled the passing of the Prince, two large factions arose, one of which delivered a determined assault on the tea and cake laagers while the other stormed the Nursing Home. It was instructive to follow some of the groups of

visitors as the beauty of the building was unfolded to their view. A satisfied sigh marked the transition to refreshing coolness when once the gates were passed; a little gasp of surprise at the marble staircase, a halt for personal observation at the mirror doors of the dining-hall and a murmur of pleasure at that noble room. But the climax was always reached when a sharp turn and a few steps brought the explorer into the swimming bath. Then arose a perfect babble of delight and many longing glances were cast on the glittering water and the fresh white tiles. Throughout the whole of our wanderings we heard nothing but praise and delight, except from an occasional dweller in the college whose feelings overcame him when he called in contrast his own quarters. Dr. Perry received many congratulations that day and an enterprising resident might have put up fifteen stretchers in Patience with impunity.

A PROPOS of the swimming bath, it is perhaps not generally known that the night nurses' quarters in the new home are grouped in its immediate neighbourhood. Consequently, when the ardent bather howls with delight he wakes up a score or so of very tired nurses, who are naturally out of sympathy with his joy of living. We feel sure that it will be unnecessary to do more than call attention to this fact; the good feeling of the men will render any further action superfluous. At the same time we might point out that the use of the bath by the men is only conditional, and permission is liable to summary withdrawal at any time should such a course appear desirable or necessary.

AT present, Tuesdays, Thursdays, Saturdays and Sundays are days reserved for students, the other days being held for the nursing staff. Suggestions are easily made, if with difficulty carried out, so it is with diffidence that we propose a plan which appears to us to have very obvious advantages. It is that no whole day should be reserved for either branch of the staff, but that the day should be split up into a number of periods, and a certain number allotted to the men and the others to the nurses. The nursing day has very definite hours, so that the allocation should present no difficulties, and all would then be enabled to have their daily swim.

ONE other point with reference to the bath and we have done. The water supply, condensed from the exhaust of the engine-room is at present of an unpleasantly high temperature but the well-known ingenuity of Mr. Barnes will doubtless soon alter this. What seems less easily remedied at present, at any rate, is the dangerous and uncanny approach to the bath. Two ways are open: the first involves a journey over yawning foundations with a plank hazard at the end. Difficult in daylight, impossible after dark. Then the second route, by way of the boiler-house, necessitating a crawl over the hissing cylinders amidst the growling grinding mechanical stoker and a descent into inky blackness. *Facile est descensus*, for there is the lift but afterwards *hic labor hic opus est.* However, we have yet a firm faith in the future.

THERE is a well-known proverb in our language that "it's an ill wind which blows nobody good." Unfortunately, the reverse is as often true; an instance in point is the erection of the balconies for patients in the medical wards. The excellence of the results which they produce is very obvious to the workers therein, and the pleasure which they give to the patients is unbounded. It is a pity, however, that, as these balconies cut off all the light from the A. H. P.'s room, another one cannot be found for these officials; they now work in the semi-twilight of a couple of nearly exhausted 16 candle-power lamps, with never a breath of fresh air to sweep away the accumulating odours. A hundred and fifty patients in a day is a large order even in a cheery, sunlit room, but with eight hours' work in the dark, diagnosis and digestion alike are prone to suffer.

WITHIN the last few days two of our Sisters have resigned their wards, Sister Patience, Miss Archdale, and Sister Cornelius, Miss Daniell. When Sister Cornelius assumed control of her ward it was known that her stay would not be long, and her resignation, therefore, is a matter

of no surprise. Sister Patience, however, has found the strain of her wards too severe, and after a year's good work has succumbed to ill-health. We wish her a speedy convalescence.

THE South African Memorial has definitely commenced to crystallize. The committee, constituted as described in the last number of the GAZETTE, met on Monday last and was presented with an entirely new suggestion. Since the stumbling block of all committees which have dealt with this matter has been the multiplicity and heterogeneity of ideas it might be thought that another and hitherto unconsidered suggestion would only aggravate matters. However, when it was proposed that an artistic drinking fountain in the colonnade might be compatible with the open space idea and within the means at disposal, the project was eagerly accepted by the committee and negotiations with artists at once commenced. The work will not be hurried, nor will the designs be accepted without full consideration, but the committee may, we think, now reasonably hope for a termination of their labours in a few months time.

WE would offer our condolences to H. M. Woodward, who is warded in Clinical with pleurisy. That he should so soon be laid up again after his attack of diphtheria is indeed an ill jest on Fortune's part. Could he see the thousands who flock to devour the daily bulletins supplied by the thoughtful clinicals, and note the pleasure when they read that he takes his brandy like a lamb, or some other equally cheering news, he would be more assured of the sympathy of Guy's than by anything we can say. We trust that he will soon be out of the wood and out of the ward. This is a joke.

DURING the last week or so a small gang of men has been at work on the lift shaft in the surgical buildings. An Otis elevator is to be placed therein, and within a very short time now the ward-clerks and dressers will cease to usurp the functions of porters. A wheeled stretcher with folding handles will convey the patient from the ward to the lift, and from the lift to the theatre. The pattern of the lift will be familiar to those who have acquaintance with the elevator in the laundry. It is of the "push-button" variety, and is so contrived that not even the most ingenious idiot can damage himself or others. A very wise precaution.

THE following paragraph from the *Sporting Times* is eloquent of the times :—

> Some of the students at St. Jeremia's Hospital put up a neat little joke on a well-known surgeon, who is said to have a partiality for diagnosing all the ills that befall a man as being caused by appendicitis. They secured an expert in fits, one of the gentlemen who, with a piece of soap and a slight knowledge of the symptoms of epilepsy, make a dishonest living from the public, and instructed him to give a performance outside the door of the surgeon's house. He gave a most artistic performance, was carried in by the servants, his collar unloosened, and his waistcoat opened. Just then the surgeon appeared on the scene, and saw neatly pinned on the sufferer's shirt-front a paper, with on it, "Please do not operate on me for appendicitis." The fit-thrower left the surgeon's house at "the double."

DR. BEDDARD and Mr. Philip Turner are to be congratulated on their appointments in the medical wards, the former on being elected to the post of Assistant Physician to the Hospital, the latter on his being the first to fill the new post of Additional Medical Registrar. That in each case the right man was selected, was the unanimous opinion of all, whilst the institution of the new Registrarship should certainly lead to a distinct advance in the direction of that systematic investigation which is so necessary for real progress.

WE have received a letter from a medical correspondent who informs us that he has a patient reputed by her father to be suffering from an "overture" of the stomach. Our informant suggests that she should consult a musical surgeon. For our own part we should prefer a Doctor of Music, for this is obviously a case that requires careful Handelling. A Mendelssohn surgeon might start Chopin her Bach and not only cause her Griegous bodily harm but Gounod good.

VOLUME LVII. of the Guy's Hospital Reports is now in the printers' hands, and the Editors hope to publish at an early date.

Opening of the Henriette Raphael Nurses' Home,

BY

T.R.H. THE PRINCE AND PRINCESS OF WALES

On July 2nd, 1902.

IN brilliant sunshine, with a goodly gathering of gallant men and fair women, the great event of the year at Guy's came and passed. As usual on these occasions academic dress was worn by all who were so privileged, and the rich hues of the hoods and the scarlet doctorate gowns gave a warmth of colour to the scene which was in itself both picturesque and artistic. Bunting and marquees lent the air of festivity but the real decorations were in the guests themselves, and in the due and proper appreciation of this fact lay much of the success of the afternoon.

The visitors were marshalled some little time before the arrival of the Royal party, and punctually at half-past three the National Anthem announced the arrival of the Prince and Princess. A procession was formed, and the President performed the opening ceremony. The following is a verbatim report of the speeches.

H. COSMO BONSOR, ESQ. (Treasurer of the Hospital): Ladies and gentlemen,—By command of his Royal Highness I will ask the Bishop of Rochester to commence the proceedings with prayer.

The LORD BISHOP OF ROCHESTER having said prayers,

H. COSMO BONSOR, Esq., delivered the following address:—Your Royal Highnesses, my lords, ladies and gentlemen,—It is my duty and pleasure as treasurer of the hospital, on behalf of the governors, medical, surgical and nursing staff, to welcome your Royal Highness the president of the hospital, and the Princess, on this memorable occasion and to thank your Royal Highnesses for consenting to come here to open the Henriette Raphael Nurses' Home, which I have just had the pleasure of showing you. May I be permitted to remind you, sir, that it is now five years since his Majesty the King, then Prince of Wales, came down to open the new buildings of the medical school, having previously inspired, and indeed carried through a powerful effort to place the finances of the hospital upon an improved foundation. The action of the king in those years will never be forgotten by the present generation of governors and Guy's men, and when the time came that as king he could no longer retain the presidency of our hospital, his Majesty gave us the best proof of his continued interest in the charity by prevailing upon you, sir, to succeed him in the office. This is your Royal Highness's first official visit, and I am expressing the feelings of everybody—governors, staff, nurses, and patients—in conveying our profound satisfaction that in times of so much stress you have been able to come to us. In common with all his Majesty's subjects throughout his vast dominions, we have watched with anxiety the dangerous illness through which the King has struggled, and we have admired his courage and his patient endurance of suffering, and sir, we can realize the great strain that has been placed on those who are nearest and dearest to him. We gratefully acknowledge the high example which her Majesty and your Royal Highness have given to us in the time of your trouble, and we thank God that to-day we can rejoice with your Royal Highness on the fact that immediate danger is past and that we may look forward with hope to the King's complete recovery. It may perhaps be unknown to many here present, how the nursing staff has increased; it may be equally unknown that within living memory the nurses lived within the basements; they were then promoted to the attics, accommodation which few people nowadays would care to put their servants into. We were aware of our need when the late Mr. H. L. Raphael was introduced to me; he took an immediate interest in our hospital, and gave £20,000 for the purpose of founding a nurses' home, with only one condition attached, that it should for ever bear the name of his late wife. We all regret that his life was not spared to see his work complete, but his family have taken and will take the greatest interest in his work. I may say that Guy's Hospital has been the pioneer of many improvements in the conditions under which the nurses work; the hours of duty and off duty so as to give the greatest relief possible, the midnight meal to our nurses, the recreation ground, and finally this Home, have all been arranged during the last five years. I think we may take it, sir, when speaking of nurses and their share in relieving human suffering, that his Majesty the King and her Majesty have always taken the greatest interest in their work. It is now many years since her Majesty the Queen first showed her interest in nurses by associating herself with the Royal National Pension Fund for Nurses, having for its object to provide nurses with old-age pensions, and with the kindred Institution, the Junius Morgan Pension Fund, which provides temporary assistance for nurses disabled by sickness or accident. We rejoice in the kindly interest which the Royal Family, and especially your Royal Highnesses, have to-day shown towards a hardworking profession. I am especially enjoined to state what an enormous gratification it is to our nursing staff that the Princess has come with you, sir, to render the great service which I now have the honour to ask your Royal Highness to perform.

H.R.H. THE PRINCE OF WALES: Mr. Treasurer, and my lords and ladies and gentlemen,—Before I allude to the object for which we are met together to-day, I am sure that all who are here will join with me in expressing our feelings of unbounded thankfulness to God for the merciful recovery of my dear father the King—(applause.)—and I wish to take this first opportunity which offers itself to say how his Majesty the King, and the Queen, and the whole of our family have been cheered and supported during a time of severe trial by the deep sympathy which has been displayed towards them from every part of the Empire. (Applause). And, speaking before the authorities of one of our leading hospitals, I should like to say that we who have watched

Opening of the Henriette Raphael Nurses' Home by T.R.H. the Prince and Princess of Wales.

The Arrival of The Prince and Princess.

Leaving the Court Room.

In the Park.

Refreshments.

at the sick bed of the King fully realise how much, humanly speaking, is due to the eminent surgical and medical skill, as well as to the patient and highly-trained nursing, which it has been his Majesty's good fortune to enjoy. (Applause.) So it seems almost fitting that one of the first public ceremonies that the Princess and I should take part in, since the King's serious illness, should be to open this beautiful home for nurses within the precincts of this great hospital which we have just had the pleasure of inspecting. It is only in comparatively recent times that the rôle of the nurse in the sick-room has been fully recognised, but are there not many here who, like myself, will throughout their lives remember with the deepest gratitude the soothing comfort, indeed I may say the *blessing*, of efficient nursing. Since the value of its work was recognised, nursing has been more looked upon as a proud and honourable career. The recent war has shown us what a benefit the country derives from having in its civil hospitals a reserve of nursing available for service in the field. We know what splendid work has been done in South Africa by the nurses largely drawn from the training-schools such as exist in this hospital—(applause.)—and I am sure the thanks of the nation are indeed due to the general hospitals who sent their best nurses to cope with the serious difficulties with which the military medical authorities were at one time confronted. Recognising, therefore, the high and indispensable position which nurses occupy, the least that can be done for them is to provide the comforts of a home where they can enjoy rest and relaxation after their hours of arduous and self-sacrificing work. It was one man who, holding this view, gave practical reality to it by the munificent gift, which has already been referred to by the treasurer, for the purpose of establishing this home which we to-day inaugurate; and I am glad as your president to congratulate Mr. Raphael, who I am happy to think is one of our governors, upon the consummation of the work of which his father was the founder, and which will for all time bear the name of his mother. (Applause.) Ladies and gentlemen, I wish to thank you for the kind reception which you have given to the Princess and myself, and I can assure you that we both feel that in coming here to-day we have only fulfilled a very pleasing duty. I thank you also, Mr. Treasurer, for all your kind allusions to the King and Queen. It is not too much to say that the King on his accession laid down with great regret his work as President of this Hospital, and also of the Hospital Fund for London which he founded and which still bears his name—(applause.)—and I am sure you all know that his Majesty continues to take the keenest interest in the progress of this fund and in the excellent work which it has done, and he looks forward to the still greater work which the organisation, now created, is ready to carry out whenever the increased funds for doing so are available. I now have much pleasure in declaring the Henriette Raphael Nurses' Home open. (Applause.)

The Right Hon. LORD ALDENHAM (a former President of the Hospital): My lords, ladies, and gentlemen,—The Treasurer has already given thanks to their Royal Highnesses in coming here to-day to open this nurses' home, but I think it is my duty, speaking not only for the governors and the nurses, but for all this assembly—I may say for all those who take an interest in the efficiency of our hospitals—to express their thanks to their Royal Highnesses for their goodness in coming here this day. (Loud applause.) Now, sir, I must look back to the time when I also, unworthily, was President of this Hospital. I fell upon evil times from a financial point of view. Happily those times improved even in my day; much more did they begin to improve when his Majesty the King became, as Prince of Wales, President of this Hospital. Again they are improving, sir, under your care and presidency, and I trust that that impetus which the presidency of the King, and the presidency of your Royal Highness have given to everybody who wishes well of the hospitals, will cause those evil financial times to depart wholly, and good times to come. Why should they come particularly? We have got, through the munificence of Mr. Raphael, a beautiful nurses' home. There are many more things that we need. To have a thoroughly good and efficient hospital we must have the buildings, including a good nurses' home, and we have them. And we must have a good staff of physicians, and we have them. We must also have good nurses, and that our nurses should be efficient there must be good lodging for them, good conditions of living for them, and that, I trust, we have and shall have. I have now to propose that the thanks of this meeting be given to their Royal Highnesses for their goodness in coming to-day to open this nurses' home, which is so great a step towards the efficiency of the hospital. (Applause.)

H. H. RAPHAEL, ESQ.: Your Royal Highnesses, and my lords, ladies, and gentlemen,—It is my privilege to second this resolution which has been proposed by Lord Aldenham, and I desire to associate myself most intimately with the remarks of thanks which have fallen from him and from our Treasurer, for the kindness of their Royal Highnesses in being present here to-day amid their manifold and multifarious duties. All of us who are interested in hospital work recognise the deep debt of gratitude that we owe to his Majesty the King and to their Royal Highnesses for the way in which they have brought the claims of the London hospitals before the public, and for the large amount of money which those efforts on their part have induced into our coffers. We recognise that were it not for the efforts which the Royal Family has made, we should have been obliged to have left many things undone, which we have been able to do, in alleviating the lot of our suffering poor who come to these hospitals. Well, ladies and gentlemen, to me and to the members of my family there is a sorrowing note in this day's festivities. He who designed this memorial, the one whose life was a record of good works and sympathetic kindness for the suffering poor, is no longer here to see the completion of his work, but it will be a source of pride to the whole of my family and to myself to know that the memory of her name and the memory of my

father's gift will go down to posterity associated with the affectionate feelings and gratitude of all those who are within these walls. And I may beg to tender to his Royal Highness my sincere thanks on behalf of my family for the kind way in which he has alluded to my father. We shall all of us recognise it as a tribute from you, sir, which we shall all of us value, and I thank you on behalf of my family for this kindly recognition. Well, your Royal Highness, all the subjects of his Majesty the King are imbued with deep feelings of loyalty and love for your Royal House, and that feeling has become intensified, and strengthened, and has grown with the knowledge that your Royal Highness takes such a great interest in the poor and suffering and in the lowliest and humblest of our fellow citizens. I have only to assure you, on behalf of the thousands who take a great interest in this hospital, that we are sincerely grateful to your Royal Highness for having come here to-day, and that this day will be a red-letter day in the annals of our hospital. I think that perhaps it will cheer your Royal Highness, in the trouble you have taken, that you will possess the knowledge that the work you have done here to-day will contribute largely to alleviating the pain and suffering of thousands, who will receive treatment in this hospital. I have great pleasure in seconding the resolution. (Applause.)

H. COSMO BONSOR, ESQ.: I think we will carry this vote with acclamation, if you please. (Loud applause.)

Among the guests present were:—H. Cosmo Bonsor, Esq. (Treasurer of the Hospital), Mrs. Bonsor, The Bishop of Southwark, Lady Barbara Yeatman-Biggs, The Mayor of Southwark, Mrs. Redman, The Mayor of Bermondsey, The Bishop of Rochester, Hon. Mrs. and Miss Talbot, Rt. Hon. Sir Joseph Dimsdale, M.P., Lady Mayoress, Rt. Hon. Lord Aldenham, Mrs. Adam Clarke, Countess of Bective, Rt. Hon. Lord Revelstoke, Sir James Blyth, Bart., Sir Frederick Wills, Bart., Sir W. Cameron Gull, Bart., Lord Henry Bentinck, M.P., Lady Henry Bentinck, Sir W. S. Church, Bart. (President of the Royal College of Physicians), Sir H. G. Howse (President of the Royal College of Surgeons), Dr. Frederick Taylor (Senior Physician to the Hospital), Mr. Clement Lucas (Senior Surgeon to the Hospital), Gen. Sir R. Harrison, Ven. Archdeacon Lawrence, Sir Joseph Savory, Bart., Sir W. P. Treloar, Sir Henry Burdett, Sir F. Green, Bart., R. K. Causton, Esq., M.P., A. L. Cohen, Esq., J. H. Benyon, Esq., M. Biddulph, Esq., R. Barclay, Esq., Frank Debenham, Esq., J. S. Gilliat, Esq., Robert Gordon, Esq., R. A. Hankey, Esq., Henry Lafone, Esq., A. J. Lawrence, Esq., C.I.E., M. T. Martin, Esq., Thomas A. Mason, Esq., H. H. Raphael, Esq., W. S. Seaton-Kerr, Esq., A. H. Smith, Esq., M.P., C. F. Raphael, Esq., W. G. Raphael, Esq., E. G. Raphael, Esq., Walter Raphael, Esq., L. E. Raphael, Esq., Mrs. A. L. Raphael, Mrs. G. C. Raphael, Mrs. Abisdid, J. N. Karpeles, Esq., Mrs. Karpeles, Mrs. John Raphael, Under-Sheriff F. R. M. Phillips, Alderman T. V. Strong, Mrs. F. D. Sassoon, E. D. Stern, Esq. Members of the Medical and Surgical Staff, and others.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The late Dr. Washbourn.

SIR,—On reading the obituary notices of Dr. Washbourn I feel tempted to add a word of my own, if you will kindly afford me a little space, a word which I doubt not will be echoed by every Guy's man who knew him. The editor of the *B.M.J.*, or whoever is the writer of the obituary notice, in referring to his brilliant scholarship and his scientific agnosticism, says, "He never stated a result until absolutely assured of its irrefutability," and who of us forgets poor Washbourn's quiet quizzical smile, whose kindliness robbed it of any grain of annoyance, when asked by an enthusiastic student his opinion on a supposed discovery or an interpretation of a symptom? Those of us who came under his influence admired the open-mindedness with which he sought the aid of a surgeon more often than most. His modesty and retiring manner endeared him to everyone, and his "out-patients" were crowded with men who even then looked upon him as Wooldridge's successor. Anyone who once could feel himself privileged enough to call himself a friend of Washbourn's was a friend for always. This trait in his character was perhaps the clue to his wonderful influence—never sought—with students. How many papers have been published by "Washbourn and X."—and if Washbourn had had his way it would doubtless have been "X. and Washbourn."

A more hard-headed, kindly, modest, steadfast man than Washbourn, Guy's has never possessed; deeply tinged with the love of sport so characteristic of Guy's, and yet, or may it not be consequently, the most brilliant student of a brilliant hospital since Wooldridge. Some of us will remember when Washbourn became a neighbour of ours in Trinity Square, a few doors off the house where Wooldridge lived, his marriage and the untimely death of his wife, little more than a bride, and our sorrow, which many of us would have liked to express to him and could not for shyness, lest he should think it "cheek," a thought very unlike Washbourn. I could never quite understand why some memorial was not put up in the school to Wooldridge, and now, why not to Washbourn?

Cardiff. J. J. E. B.

The Hereafter.

SIR,—While congratulating the writer of the above article, in your number of June 21st, on the variety of his cases and on his acuteness in dealing with them, I would most strongly condemn the tone in which he refers to his brother medicals and their work. His whole attitude seems to say, What a clever man I am and what fools the other people are! It is this attitude

which is responsible for the endless misunderstandings which occur in practice and which account for the well-known want of union of our profession as a body.

Let me tell "Spero" there is a way of getting on other than going one better than the other fellow, and by all means let it be by mutual association and help, and by minimising rather than making the most of the mistakes of others. Of course, I am quite aware this means self-sacrifice, especially when one is a beginner, but it inevitably pays in the long run, and assuredly leads to respect and esteem by our brother medicals, which is certainly likely to be wanting in the course which "Spero" advocates.—Yours, etc.,

R. H. F.

The Biennial Dinner.

IT would be impossible to imagine a more successful evening than the latest Biennial Dinner. If it were merely that old Guy's men of all years and all ages make this a worthy excuse for renewing old friendships and meeting in concord under the common tie of student-ship at *the* hospital, sufficient reason were present for wishing long life to the festival; when, therefore, it is considered how much there is in these reunions that can be of real use in the advancement of the alma mater and the individual members who go to make up the body corporate, even the most rigid Puritan could scarce refrain from commendation.

After the usual loyal toasts in which Dr. GALABIN, the Chairman, alluded to the profound grief that the nation had experienced in the King's illness, the toast of the evening, "Prosperity to Guy's Hospital and its Medical Staff," was proposed by the same speaker.

There were some Guy's men, he supposed, who only came to London once in two years, and then for such an occasion as this. This remark caused considerable consternation among some of his auditors, who seemed apprehensive of further revelations. They could not fail to be struck, he added, with the great structural alterations that had taken place in the old hospital. Speaking as a mathematical expert, he had himself noticed an axial asymmetry about the front quadrangle that somewhat displeased him. But when he investigated the cause and saw that the front surgery had gained immensely by this lateral hypertrophy his displeasure was changed to admiration. Nor did the alterations for good cease there. The observant and intelligent spectator would notice that the wards had been enriched with balconies for the greater comfort of the patients, and in Queen Victoria Ward, where he was perhaps most at home, he was able to note at least one case where an almost miraculous recovery had been effected through the agency of good fresh air on the balconies. The cost of these improvements was, he need hardly say, considerable and had yet to be defrayed. However, he had no anxieties as to the future, and was convinced that the sterling genuineness of the improvements would attract a sufficiency of supporters. Meanwhile they had been forced to employ those measures which had called for such hearty approval from Gladstone, himself a master of finance, when the College was opened; they had pledged the credit of the Medical School. Much had been done towards rendering the buildings of the Medical School as perfect as our knowledge permits. The Governors in their official capacity helped with advice and sympathy, and in their private capacities generously opened their pockets and gave largely. Sir Frederick Wills had given the new library which was to be opened in six months time. Mr. Robert Gordon had endowed a lectureship in experimental pathology, and Mr. Pierpont Morgan had given a thousand pounds for the advancement of medical education. Through these and kindred generous deeds he hoped that Guy's would still continue to add names to the golden roll of illustrious physicians and surgeons. Perhaps we could hardly hope to give names to any more diseases; the days of Addison and Bright were gone and men preferred now the hybrid polysyllabic atrocities of mock erudition to the simple nobleness of a great Englishman's name. Still there were amongst us even now great names, names that had still much of the old force and charm. He need only mention his old friend, Sir Samuel Wilkes (loud applause), and the latest honour to Guy's, Sir Henry Howse (prolonged cheering, and cries of a familiar though affectionate nature). Bryant and Fripp, both honorary surgeons to the King, had brought us honour, and there were many others who had added, and would add to the credit of the old place. He could not refrain from deploring the immense loss that Guy's, and indeed the whole scientific world, had sustained in the death of Dr. Washbourn; and in the untimely end of Dr. Patrick Manson a most promising man had passed away. The war, now happily ended, had shown that no field could exclude us from a share in the honour roll, and men and nurses alike had proudly upheld the credit of Thomas Guy. He was glad to be able to state that a worthy memorial to the eleven Guy's men who gave their lives to their country in South Africa would shortly be raised in the hospital. Such a monument would always act as an incentive to later generations of Guy's men, and he had no fears that in the future, should the necessity arise, there would ever be found many who would cheerfully follow the path of duty and patriotism, even to death. With an eulogy of the Treasurer, which found hearty response among all present, the Chairman concluded his speech.

Mr. COSMO BONSOR, in reply, said that, despite Dr. Galabin's remarks to the contrary, Guy's Hospital had existed for two hundred years without reform and with little or no change. "Guy's Hospital, gentlemen, can never change, and therein lies her greatness." Apparently, however, the geographical aspect of the hospital could change, for he was forced to believe that, instead of lying in the valley of the Thames, it had been transported to the summit of one of the heights of England; at any rate, on the night when the bonfires blazed out on the high places round England, the resident staff and

students of Guy's followed suit with a bit of a flare up round Thomas Guy's statue. Incidentally, six barrels of tar were missing in the morning. Guy's is poor and lives in hope; may she never be disappointed. Her staff are rich; may they never disappoint her. Again he must emphatically state that the old building has not changed a jot. The Guy's man of forty years ago still finds the same old dressers' room, with the same old furniture. And later generations have told him that they have recognised in the fives court the same old gaps and flaws that exasperated them years ago. While the men remain loyal to her Guy's will never change, and of this he was devoutly thankful.

Sir Cameron Gull was not aware what special qualification he possessed for proposing the health of the Imperial Forces unless it was that years ago, while a sergeant in his school corps he ordered section volleys to be fired at the G. O. C. and his Staff, and thereby provoked language in his captain and house master that was vivid and lurid. Still anyone would be delighted to honour our army in any shape and form, and he welcomed the privilege. Surgeon-General Beatson briefly responded.

In proposing the health of the Consulting Staff, Dr. Taylor remarked that they never lost touch with the hospital. Sir Samuel Wilks was a familiar figure at the opening meetings of the Physical Society, and Dr. Pavy held a unique record of attendances in his capacity of President of the Debating Society. Dr. Pye-Smith, too, was an ever welcome visitor, and Sir Henry Howse, the youngest of the Consulting Staff, had by no means cut himself off from the old hospital. He then gave some details of the work by which the various members of the Consulting Staff had become famous, and earned a hearty response to his toast.

Sir Samuel Wilks, in reply, apologised for deficient vocal powers on the grounds that he had just made the acquaintance of a, to him, new disease. He had had hay asthma, and after some difficulty, had become well enough to go home. He then found that his people entertained beliefs that the disease was infectious, and his welcome was by no means cordial. In the interests of science he commenced a search among the literature with the view to disproving the theory of contagion. His efforts would have been quite successful but for a single case, recorded by an American physician, of a man contracting hay fever from kissing a grass widow! Referring to the King's illness, he said that the most masterly monograph on appendicitis in the English tongue, a treatise moreover which could receive no addition, even at the present time, was written by Addison sixty-five years ago. He called on the Gazette to reprint this paper.

When Mr. Bryant had also replied to the toast, proceedings were interrupted by cries of "Pulpy," and in response, Sir Henry Howse modestly replied. The drinking of the healths of the Chairman and of Dr. Pitt, the Hon. Secretary, closed a singularly successful evening.

Nursing News.

Matron's Office.

The Henriette Raphael Nurses' Home was opened by T.R.H. the Prince and Princess of Wales on July 7th. The weather was most propitious, the Home, Hospital Grounds, Wards, etc., being crowded with visitors. The Home, which had been tastefully decorated, looked charming and was greatly admired by everyone. A great number of past nurses availed themselves of the invitation sent out to members by the Council of the Guy's Nurses' League and visited their training school. Sister Lilian, Miss Tippetts, has been appointed Home Sister.

On July 11th, Nurse Tilley left the hospital on completion of her three years' training, and Probationer M. Dixon was appointed to succeed her as Head Nurse in Bright ward.

Pass List.

University of Cambridge, June, 1902.

EXAMINATION FOR THE DEGREE OF DOCTOR OF MEDICINE.

J. N. Gardiner.

Royal College of Surgeons of England, May, 1902.

FINAL PROFESSIONAL EXAMINATION.
FELLOWSHIP.

F. Curtis, E. J. O'Meara, T. Pettey, J. F. Robinson, D. G. Greenfield, E. E. Henderson.

South African Memorial Fund.

FOURTEENTH LIST OF SUBSCRIBERS.

	£	s.	d.
Amount already acknowledged	235	7	6
R. Wynne Rouw	1	1	0
W. W. Henson	0	10	6
T. D. Manning, M.B.	0	10	0
J. M. Thorne	0	7	6
	£237	16	6

Papers by Guy's Men.

Vermiform Appendix, containing fæcal concretion on a black pin, removed after death from a child aged six years. Illustrated. By John D. Malcom, F.R.C.S.—*The Lancet*, July 5th.

On the Acetone Series of Products in connection with Diabetic Coma. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S.—*The Lancet*, July 12th.

Sport.

Cricket.

GUY'S v. GRAVESEND.

This match was played at Gravesend on July 2nd. Gravesend compiled 127 and Guy's, owing to a fine stand by R. Willan, Senior, and Carter for the ninth wicket, replied with 140, thus winning by thirteen runs. Both teams enjoyed once again the kind hospitality of Dr. R. J. Bryden. Scores:—

GRAVESEND.

	1st Innings.	2nd Innings.	
L. K. W. Troughton, c & b Wyatt	12		
L. C. Troughton b Foster	15		
F. Boorman, c Morres, b Willan Junior	42		
E. G. P. Caseley, b Wyatt	9		
F. H. Stevens, b Morgan	16		
— McCaulis, b Morgan	1	run out	6
B. Tabrum, b Willan Jr.	3		
R. J. Bryden, c & b Willan Junior	1	not out	47
F. Jackson, c Miller, b Willan Junior	10	c & b Willan	13
T. Shelverton, st. Collins b Willan Junior	6	b Morgan	0
E. M. Siddell, not out	2	b Morgan	0
Extras	10	Extras	2
Total	127	Total	68

GUY'S.

E. Morgan, c L. H. Troughton, b Caseley	27
J. Bookless, c Tabrum, b Caseley	1
E. A. Collins, c & b Boorman	19
F. Morres, b Casely	3
H. D. Wyatt, b Caseley	4
R. Willan Jr., b Boorman	3
E. L. Norton, c Stevens, b Caseley	9
R. Willan Sr., b Boorman	41
A. L. Foster, b Boorman	0
H. H. Carter, not out	28
C. H. Miller, b Boorman	2
Extras	3
Total	140

GUY'S v. ENFIELD.

Enfield unfortunately turned up without a full team, only 9 men batting. Guy's won somewhat easily, the scoring throughout the team being consistently good. Willan again bowled well taking 5 wickets for 33 runs. For our opponents Toms batted brilliantly and Leggatt bowled well. Scores:—

GUY'S.

J. Bookless, b Leggatt	18
H. D. Wyatt, lbw, b Leggatt	21
R. Willan, Jun., b Leggatt	8
F. Morres, b Burns	27
H. M. Langdale, lbw, b Burns	11
E. Morgan, b Leggatt	24
E. A. Collins, b Leggatt	4
H. M. Tolhurst, b Leggatt	8
E. L. Norton, not out	11
J. T. Hicks, c E. Toms, b Leggatt	27
M. G. Louisson, lbw, b Burns	34
Extras	37
Total	230

ENFIELD.

A. E. Jones, b Willan	12
H. L. Toms, c Norton, b Willan	76
E. Toms, c Louisson, b Wyatt	0
M. Jenkins, c & b Willan	26
H. W. Smith, c Collins, b Wyatt	0
J. T. Burns, c Louisson, b Willan	8
W. M. Robson, st. Louisson b Willan	5
G. M. Pratt, not out	14
W. Simpson, b Morgan	3
L. M. Leggatt, absent	
Extras	7
Total	151

GUY'S v. ADDISCOMBE.

This match was played at Addiscombe on Saturday, July 12th, and after a close finish resulted in a win for our opponents by the narrow margin of 4 runs, the scores being—Guy's 160, Addiscombe 164. Collins played an excellent innings for 53, and Bookless and Norton also made useful scores. Hicks bowled very well, taking 5 wickets for 51 runs, and Willan 3 for 49. Scores:—

GUY'S.

J. S. Bookless, lbw, b Robarts	34
E. Morgan, c A. Wiltshire, b Kenward	0
R. Willan, Jun., c Dyer, b Brown	14
F. Morres, c Kenward, b Brown	0
E. A. Collins, c A. Wiltshire, b Moore	53
E. L. Norton, c Ashcroft, b Kenward	24
R. Willan, Sen., b Kenward	0
A. M. Tolhurst, c & b Moore	6
J. T. Hicks, c Dyer, b Moore	0
M. G. Louisson, not out	9
H. H. Carter, c Robarts, b Brown	12
Extras	8
Total	160

ADDISCOMBE.

E. Wiltshire, c Norton, b Hicks	22
H. G. Roberts, st Louisson, b Willan	37
R. L. Turner, c & b Hicks	0
A. Wiltshire, c & b Hicks	16

E. F. Dyer, lbw, b Willan	21
C. Kenward, c Carter, b Hicks	8
F. W. Robarts, run out	43
M. M. Moore, b Bookless	0
A. C. Beaton, c Willan Sen., b Willan Jun.,	12
E. C. Ashcroft, b Hicks	4
H. Y. Brown, not out	0
Extras	1
Total	164

GUY'S 3RD XI. v. SEVENOAKS SCHOOL.

This match was played at Sevenoaks and ended in a win by 32 runs Harvey took 5 wickets for 1 run and Leeming played a good innings of 35. Scores :—

SEVENOAKS SCHOOL.

Rigby, c Wight, b Vernon Taylor	15
Dummère, b Bartlett	0
Fraser II, b Bartlett	0
Fraser I, c Fox, b Bartlett	5
Ingall, b Bartlett	0
Dorn, c Ellis, b Harvey	6
Armstrong, c Wight b Harvey	0
Vardon, b Harvey	0
Willis, c Bartlett, b Harvey	0
Stevens, c Brookhouse, b Harvey	0
Tundall, not out	1
Extras	4
Total	31

GUY'S.

T. R. Harvey, c Ingall, b Fraser I	0
E. N. Fox, c Dorn, b Fraser I	5
G. N. Bartlett, c Armstrong, b Fraser II	0
W. H. Miller, b Armstrong	9
A. Leeming, lbw, b Fraser I	35
A. D. Vernon Taylor, b Stevens	2
R. Ellis, c Armstrong b Fraser I	3
H. O. Brookhouse, not out	1
J. T. Smalley, c Dorn, b Fraser II	0
Wight, run out	0
W. Wood, c Dorn, b Fraser I	0
Extras	6
Total	63

Guy's Hospital Lawn Tennis Club.

THE HOSPITAL CHALLENGE CUP.

The annual competition for the Inter-Hospital Challenge Cup, was held on the Chiswick Park L.T.C. Ground, on Wednesday, Thursday and Friday, July 2nd, 3rd and 4th.

In the first round, Guy's beat St. Bartholomew's by 5 events to 1 in the singles and 3 all in the Doubles, thus winning by 8 events to 4. In the 2nd round, St. George's beat Guy's by 9 events to 4 after winning the singles by 5 matches to 1

In the final, London beat St, George's by 8 events to 4.

Guy's v. St. Bartholomew's. Won by Guy's by 8 events to 4.

Singles.—F. W. M. Palmer, beat J. G. E. Slade, 9–7, 1–6, 6–4; T. C. Lucas lost to E. H. Hunt, 3–6, 9–7. 3–6; E. N. Jupp beat A. Hamilton, 3–6, 6–2, 6–2; B. H. Wedd beat C. A. W. Pope, 5–7, 6–2, 6–4; C. H. Winckworth beat P. Black, 8–6, 6–4; A. Zorab beat P. W. Leathart, 6–4, 8–6.

Doubles.—Palmer and Lucas beat Hunt and Pope 6–2, 6–4, lost to Black and Hamilton, 1–6, 4–6; Wedd and Winckworth lost to Black and Hamilton, 2–6, 3–6, beat Leathart and Slade, 6–4, 2–6, 6–1; Jupp and Zorab beat Leathart and Slade, 6–3, 6–4, lost to Hunt and Pope, 4–6, 4–6.

Guy's v. St. George's, semi-final tie. Won by St. George's by 9 matches to 4, 19 sets to 10, 151 games to 121.

Singles.—T. C. Lucas lost to A. S. Bradley, 6–3, 7–9, 0–6; F. W. M. Palmer lost to H. B. McCaskie, 0–6, 2–6; E. N. Jupp lost to W. T. Scott, 3–6, 1–6; B. H. Wedd lost to G. A. Jones, 4–6, 5–7; C. H. Winckworth lost to C. R. S. Bradley, 5–7, 6–4, 3–6; A. Zorab beat A. G. E. Wilcock, 6–1, 7–5.

Doubles.—Lucas and Palmer lost to Bradley and McCaskie, 2–6, 1–6, beat Scott and Jones, 6–4, 4–6, 6–4, beat Bradley and Wilcock, 6–1, 6–0; Jupp and Zorab lost to Scott and Jones, 3–6, 4–6, beat Bradley and Wilcock, 6–3, 7–5; Wedd and Winckworth lost to Bradley and Wilcock, 6–8, 4–6, lost to Bradley and McCaskie, 4–6, 1–6.

GUY'S v. KENT L. T. C.

This match was arranged for July 12th, at Honor Oak Park. Owing to the inability of Kent to raise a team on account of the Inter-County Cup Competition, this match was scratched.

Births.

HARE.—On June 28th, at the Hermitage, Minchinhampton, Glos., the wife of Major E. C. Hare, I.M.S., of a daughter.

ROBINSON.—On June 8th, at the Sanatorium, Durban, Natal, Dr. Lilian, wife of F. Austin Robinson, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

BALDERSTON — CULLIFORD. — On June 24th, at Christ Church, Clifton, by the vicar, the Rev. T. C. Chapman, M.A., Robert Balderston, M.B., of Forest Hill, to Ethel Madelaine Ella, only daughter of the late James Henry Culliford, of Clifton, Bristol.

BOOKER—MAY.—On July 5th, at St. Mary's, Kelvedon, Essex, Charles William Booker, F.R.C.S. Edin., of Witley, Surrey, to Ada Constance, third daughter of the late George May, of Triptree Hall.

ED.—A. P.

Contents.

	PAGE
Addison on Appendicitis	309-313
In the Medical Wards	313
Erosion. Paper by Mr. T. A. Donald	314-318
Passim	319-323
Case for Diagnosis	323
The Society of Medical Phonographers	323
Revised Syllabus for L.D.S. Examination	323-324
Correspondence: The Wooldridge Memorial; Guy's Hospital Clubs' Union; The Hereafter	324-325
Guy's Hospital Clubs' Union—Annual Report and Balance Sheet	325-326
Sport: Cricket—Guy's v. Eltham; Guy's v. Wellingborough Masters; Cricket Season 1902, Analysis. Guy's Hospital Rifle Association	327-328
Papers by Guy's Men	328

Guy's Hospital Gazette.

AUGUST 2, 1902.

Addison on Appendicitis.

(Published in 1839.)

Inflammation of the Cæcum and Appendix Vermiformis.

That portion of the intestine which is lodged in the right iliac region is frequently the seat of inflammation and affords peculiar symptoms, with which it is right that the student should be well acquainted. The history of this affection is often as follows :—The patient has complained, more or less, for some time past, of pain and uneasiness in this part, increased on exertion, or after neglect of the bowels, or excess in eating or drinking; he has, however, retained such a share of health, that he has not been interrupted in his daily avocation, till, after some unusual exposure to cold, or some long walk, or other over-exertion, he has been suddenly seized with more severe pain, attended with rigors, chills, and sometimes with sickness and violent vomiting. The pain and tenderness become excessive, and extend to the neighbouring part of the abdomen. A hardness and tumefaction are soon very evident to the hand in the parts first affected; this continuing, general symptoms of peritonitis often take place and terminate fatally, but under careful treatment the inflammation remains circumscribed and becomes even less extensive, assuming the form of a local deep-seated abscess. The threatening symptoms of peritonitis subside, the tumefaction just above the crest of the ilium on the right side is more and more obvious to the touch, and gradually shows a tendency to point, the constitution still suffering severely. In process of time it either opens of its own accord, or is assisted by the lancet, and a discharge of ill-conditioned pus follows, which, from its peculiar fetid smell, and from its appearance, is soon discovered to be mixed with feculent matter. The discharge continues for many weeks, and the patient dies at length from exhaustion. In other cases, when the powers of the system are previously unbroken, the abscess closes, and permanent recovery is obtained.

Morbid appearances.—From numerous dissections it is proved that the fæcal abscess thus formed in the right iliac region arises, in a large majority of cases, from disease set up in the appendix cæci. It is found that this organ is very subject to inflammation, to ulceration, and even to gangrene; and, moreover, that it is occasionally thickened and ulcerated from tubercular deposits, if the peculiar diathesis favours that change, so that this little wormlike body is often detected in the midst of the abscess with a perforation at the extremity, or by ulceration higher up in its parietes. A considerable portion of it nearly or entirely separated, is found in a disorganised condition among the pus and the fæces which form the abscess. In other cases the appendix is truncated within a short distance of its origin from the cæcum. In a smaller number of instances the cæcum itself is found inflamed and ulcerated and extensively implicated in the abscess in a way which shows that the appendix had little to do with the disease. According to the circumstances under which the patient has died, the extent of the abscess will be greater or less; it will be more or less circumscribed, and more or less complicated with diffused peritoneal inflammation.

It is but seldom that the abscess is very perfectly insulated, for the nature of the matter which it contains does not favour the production of a healthy adhesive process; but still it often becomes circumscribed towards the cavity of the peritoneum while it burrows behind that membrane and finds its way into the surrounding cellular tissues, so that it sometimes points at a considerable distance from the original source of the disease.

Exciting causes.—It is possible that the secretions of the appendix itself may sometimes become diseased and give rise to inflammatory action in the part; sometimes we can plainly discover that stricture, amounting even to occlusion of the cavity, has taken place, so that the extremity has been distended with its own secretion, and this may probably give rise occasionally to inflammation; at other times we find little oval masses of fæces impacted in the canal, which have pretty obviously produced the irritation; sometimes a foreign substance, as a cherry stone, or other seed, has been detected in the appendix; but one of the most common causes is undoubtedly the formation of a peculiar concretion which is moulded to the extreme cavity of the canal, and which is composed of coats or layers of the earthy phosphates, with occasional alternate layers probably of animal secretion or of feculent matter. Although a fæcal abscess forming in the right iliac region will, as we have said, generally be the result of disease in the appendix, yet in some cases the mischief is found to have originated from inflammation of the cæcum itself, or of the cellular tissue in its immediate vicinity.

That viscus, from its peculiar structure, and probably from the fact of its function requiring a certain delay of the fæcal matter in its cavity, is very liable to suffer from irritation and inflammatory action, which would appear to be occasionally communicated to the cellular substance by which it is bound down, or to the portion of the peritoneum and parietes with which it is held in constant contact; indeed, the injurious causes to which the cæcum is exposed correspond very nearly with those of the appendix, for we find in it, likewise, the secretions vitiated; and we find foreign matters, such as plum stones and other hard and indigestible substances lodging in it till inflammation is produced; and in some districts of the country we have concretions generated in the cæcum of a character very analogous to those which produce so much disease in the appendix, formed like them of alternate layers of the earthy phosphates and of some fæcal matter; and as these concretions generally occur in districts where the oat constitutes the principal aliment, the intermediate layers have been found chiefly composed of the fine hairs which belong to the internal husk of the grain, collections of which have appeared to be the original exciting cause of the irritation in the cæcum. These concretions frequently increase to a very large size, filling the head of the cæcum, and, as may well be supposed, excite the greatest irritation, leading to the thickening and ulceration of the different tissues of the intestines.

Diagnosis.—The situation of this disease in the right iliac fossa will often sufficiently point out the probability of its nature; yet it will require much tact, and the habit of such observation, to decide with certainty from this alone; and the chance of error will be the greater, because, owing to the occasional burrowing of the abscess it may become most prominent at some distant part, so far in the loins, for instance, as to suggest the idea that the kidney is implicated, or so high up, that if some surrounding hardness should occur it may be referred even to the liver, or so far towards the pubes as to render it not impossible that the tumour may depend upon disease of the pelvic viscera. Moreover, an abscess situated as this is will often produce symptoms not unlike those which exist in nephritic attacks, a pain and numbness down the thigh, and a retraction of the testicle, which, coupled with the sickness and the pain or tension extending towards the loins, will render the diagnosis in some few cases still more difficult. In general, the manifest irritation, or the deranged action, and even the constipation of the bowels will assist us in distinguishing such a fæcal abscess as is the present subject of consideration, from every disease of the kidney and liver, and likewise from abscesses formed in the parietes of the abdomen, whilst in this we shall be further aided by the absence of some symptoms peculiar to the other forms of disease. We shall perceive neither blood nor pus in the urine, nor will its quantity be greatly reduced nor greatly augmented as might be expected if the kidney were involved, nor shall we observe the jaundiced complexion, nor the yellow conjunctiva, nor the dark yellow urine which attend upon hepatic disease.

Our prognosis will depend very much on the general health of the individual and the time of life; and if both be favourable, the disease, though always of a most doubtful and dangerous character, will often slowly yield to cautious treatment. In the individual case the more favourable indications will be found in the mildness of the general symptoms and the absence of peritoneal inflammation; whereas, if the contrary should be the case, the abdominal tenderness become extreme, the prostration great, and sickness, purging, and hiccough supervene, our hopes of recovery will of course diminish; and whenever a fæcal abscess has established itself, we are certain that the patient has to undergo a tedious process in which the strength may gradually give way, or many casualties may arise to give a more sudden unfavourable turn to the disease.

The treatment in this disease is both general and local. The former must be regulated by the degree of constitutional affection and the extent of inflammatory action. If these are considerable, general bleeding will be requisite in the early periods of the attack, and leeches should be freely applied to the part, followed by the assiduous use of fomentations and poultices. The bowels must be unloaded by mild but effectual purgatives; and these must be assisted by injections of soap and water, or gruel, or other bland liquids, in sufficiently large quantities to favour the complete emptying of the large intestines. At the same time we must endeavour to disturb the part as little as possible, for, although from the situation of the local disease, and the comparatively fixed character of the viscus, which is generally involved, there is less probability of the contents of the intestine or of the abscess becoming extravasated into the peritoneal cavity; yet this may happen if much violence is done in our manual examination, and we must always hold in mind, that though our first object must be so to allay the inflammation as to prevent the formation of an abscess, yet much more frequently we shall be called upon to prevent an ulceration and abscess, which are inevitable, from doing essential and extensive mischief. As soon as the abscess has approached the surface it must be carefully opened, and without any violent manipulation, must be encouraged by poultices to discharge its irritating contents, that the surrounding parts may assume as quickly as possible, a healthy condition. In the meantime, the action of the large intestines must still be encouraged by mild injections, and the general health must be supported, and if the age and constitution be favourable, the abscess will after a time be closed. Should the peritoneum in the earlier or later part of the progress of the disease become inflamed, the treatment must be conducted as in other cases of peritonitis.

[In 1857 Dr. Habershon published his work on Diseases of the Alimentary Canal. His article on Diseases of the Appendix and the illustrations of the disease to be found in the Museum are not without interest in connection with Dr. Addison's paper. His view of the use of the appendix is shown in his preliminary description—"The appendix is an elongated gland of very simple character, reminding of the pancreatic cæca of the intestine of the fish. As far as is present known, its secretion is of the character of ordinary mucus. Since the fæces have become solid, were it not for such a secretion, assisted by that of the ordinary mucous follicles, adhesion would be more likely to take place with the parietes, and distension would be the result. The secretion is poured out at that part which is most likely to effect this separation, namely at the origin of the triple muscular band. . . . It is probable that diminished secretion from the appendix cæci may favour the accumulation of fæces; which is often amongst the existing causes of serious disease and requires attention." Broadly speaking, Dr. Habershon divided his cases of intestinal pain and disturbance in the right iliac fossa into two classes—those due to distension of the cæcum (cæcitis) from various causes, and those due to disease of the appendix itself. It is noteworthy with respect to this differentiation that of the ten cases of cæcitis which he quotes, eight were discharged cured, one died of phthisis, in which the appendix was healthy and the cæcum inflamed, whilst in the tenth a perforation of the cæcum (? position) and abscess supervened, followed by death. Of the seven cases of appendicitis quoted, all were verified by post-mortem examination.

Dr. Habershon's diagnosis between a distended and inflamed cæcum and a consequent appendicitis rested upon the severity of the symptoms and upon the presence of signs of perforation and general peritonitis.

"Ulceration and perforation of the intestine are much more frequently found associated with disease of the appendix than with ulceration of the cæcum itself; this, however, is sometimes the case. When perforation from ulceration of a non-cancerous character takes place, the attached surface is often affected. The disease then extends into the cellular tissue in the iliac

fossa; pus burrows beneath the fascia, and opens below Poupart's ligament, on the thigh, or near the crest of the ilium. These cases are, however, rare; ulceration of the appendix cæci much more frequently leads to adhesion of the peritoneum, fæcal abscess, or general peritonitis. . . . . It is impossible to distinguish perforation of the ilium in struma or phthisis from perforation of the appendix cæci; it is, however, of little moment, since the remedial agents which are likely to be of service in these almost universally fatal cases are precisely similar in both,"

The description of inflammation of the cæcum from distension introduces a clinical picture which bears a very close resemblance to that produced by an inflamed appendix:—

"The distension of the cæcum induces local enteritis; inflammation of the mucous membrane, of the cæcum, and of the peritoneum which invests the part. These constitute a numerous class of cases, which are happily more tractable than those in which peritonitis is set up by a concretion in the appendix cæci. The mucous membrane is congested, its secretion altered, the fæces adhere to it, the muscular coat is unable to propel its contents, which constitute a tumour felt on palpation, and the inflamed peritoneum produces tenderness. In some cases this tumour consists of portions of intestine united by inflammatory adhesions, and in still more rare instances it is composed of effusion behind the cæcum, in the iliac fossa."

With regard to the concretions to be found in the appendix, Dr. Habershon divides them into three classes:—

"1. Extraneous bodies are found, consisting of nails, pins, stones of fruit, shot, bristles of a tooth-brush, entozoa, and most frequently, fæces.

2. Found in the appendix as concrete or albuminous mucous. These are not uncommon, and constitute firm semi-transparent masses, which, when dry, are fragile, and free from earthy matter.

3. Calculi, which generally present a nucleus of fæces, or of some foreign body.

I have frequently found the appendix filled with fæces; sometimes in its whole length, or forming one or more hard nodules. These minute fæcal masses very frequently form the nucleus of calculi, and become incrusted with layers, composed of carbonate and phosphate of lime, according to the analysis of one of these by Dr. Odling, as also the analysis of Dr. Golding-Bird. A concretion examined by Dr. Prout was found to consist of phosphate of lime, with a little carbonate, and small quantities of animal and oleaginous matter. Thus constituted, layer after layer becomes applied, till the size of a cherry stone is attained; and many of the so-called cherry stones in the appendix are thus constituted. The calcareous matters appear to be derived from the mucous membrane itself; in the same manner as a calculus in the urinary bladder becomes encrusted with phosphate of lime from the abundant mucus thrown out from the irritated surface. In some cases a larger size is attained, and the mass becomes as large as a date stone or a hen's egg. In the museum of Guy's (No. 1893[25]) is a large calculus the size of a hen's egg, its surface rounded and fissured; it was removed from a sinus leading from the parietes of the abdomen to the cæcum. No appendix was found, but a large abscess extended from the cæcum to the liver."

The following are brief notes on cases quoted by Dr. Habershon, of which specimens have been preserved in the Museum at Guy's.

Preparation 1879[20].—Michael R., æt. 34, admitted September, 1835, under Mr. Key. Sudden pain in right iliac fossa four days before admission, after four days of diarrhœa. A swelling appeared and suppuration supervened. Leeches were applied and antimony administered. Six weeks after admission abscess was opened and ʒviii of pus evacuated Phthisis developed, and he died in the following June. Appendix was thick, opaque, filled with a pasty fluid, and communicated with cæcum. Two openings existed above the right groin, which communicated with the cæcum.

Preparation 1832[75].—Thomas T., æt. 24. Three days before admission seized with vomiting, tenderness of abdomen and constipation. Pain on admission in right hypochondriac and lumbar region very severe, vomiting frequent. In three days pain subsided, and bowels acted freely; afterwards abdomen continued tender; prostration; delirium and death. General peritonitis was found, with several ulcers in lower part of ilium; in the right iliac fossa a circumscribed fæcal abscess contained the appendix cæci, which was nearly divided by an ulcer in its middle portion.

Preparation 1881[20].—Mrs. L., æt. 45, sudden pain in right iliac fossa; abdomen distended, tympanitic, and generally tender. Pulse weak. Extremities cold. Death on third day. General suppurative peritonitis was found; appendix distended by an elongated fæcal concretion about the size of the little finger, with a minute perforation two-thirds of an inch from its mouth.

Preparation 1881[10].—George N., æt. 20, admitted October, 1828. Severe pain in right hypochondriac region; paroxysmal in character and increased by respiratory movements. Died, apparently from syncope, after being removed from warm bath. General peritoneal cavity was found to contain an opaque, whitish, fusiform fluid, which escaped from the right side, where was a circumscribed cavity bounded by the liver and gall-bladder above, by the parietes behind and on the outside, and by the ilium and colon on the inner side; these parts, feebly glued together, contained about twelve ounces of pus. Two inches from the mouth of the appendix was a concretion of the size of a pea, and immediately beyond this an ulcerated opening about three-quarters of an inch in length, which very nearly detached the lower third of the appendix.

In two other cases from the Museum Records the number of the preparation is not given:—

M. C., æt. 22, on May 5th, 1829, had abdominal pain after excess of food, followed by partial recovery. On

May 9th severe pain set in again, with vomiting and prostration. Death occurred on the 14th, shortly after delusive symptoms of improvement. Post-mortem, there was found an abscess cavity on the right side bounded by small and large intestine and omentum, and containing two ounces of feculent pus. The appendix cæci contained an indurated concretion of the size of a "chocolate nut," which was composed of indurated fæces; a small perforation had taken place.

William J., æt. 30, was seized with severe pain in right iliac fossa sixteen days before admission. Occasional vomiting. He had a fit before admission, and since the onset of the pain had passed less urine. After admission he had several rigors, and his intellect was disturbed; he passed no water, but a small quantity of highly albuminous urine was drawn off; he also had occasional hiccough with twitching of the face. After free purgation he sank and died. Post-mortem, adhesions were found between the abdominal parietes and the colon and ilium, whilst the appendix, with a portion of the cæcum, was destroyed by ulceration. The ileo-cæcal valve was also ulcerated.—[ED., G.H.G.]

In the Medical Wards.

CASE UNDER DR. SHAW.

Female, æt. 45, was admitted into Mary, under Dr. Shaw, for constant vomiting and extreme prostration.

History.—For several years she has always been ailing, and has always been troubled with the bowels. She has often had attacks of diarrhœa, and at other times has had to take medicine in considerable doses to get the bowels open.

She has always had a very bad appetite, and at times suffered from indigestion, which was never very bad. For the past few weeks she has vomited occasionally and brought up greenish material in small quantities, which had no particular odour. For the last few days she has vomited similar material many times during the day, and has been laid up in bed.

The patient is extremely exhausted, and can give no account of herself; but her friends say that until she lay up three days ago she had little pain, and it does not seem to have been very severe until the day of admission. The bowels were opened twice on the day before admission.

Condition on admission.—Patient is apparently constantly desiring to vomit, and every few minutes brings up a small quantity of bilious material. Her face is extremely pinched and sunken, and she is extremely restless. She can only be made to answer coherently occasionally. Every now and again she has attacks of abdominal pain, and rolls about in bed and groans.

The temperature is subnormal, and the pulse 160, very weak and of a running type. The breath had a sweetish sickly odour.

The abdomen is moderately distended, chiefly in the region of umbilicus. No coils of intestine, and no peristalsis can be seen. The abdomen is supple, except when the attacks of pain came on, when the abdominal walls became rigid. No lumps could be felt. All over the abdomen a sensation akin to a succussion splash could be felt. There was dulness in both flanks, which were movable. The liver dulness was present, and over the area of the liver a rub could be heard, which was thought to be peritoneal in origin.

On rectal examination, about an inch inside the anus, a definite stricture could be felt, which would not admit the tip of the finger. The mucous membrane below the stricture was quite soft, and the surface was slightly roughened. The stricture itself was not hard, showed no evidence of ulceration, and did not apparently invade surrounding parts. From these reasons the stricture was thought not to be of malignant variety.

It was thought that peritonitis was more probable on account of the fact that the distension was not a marked feature, and that although patient had been vomiting for three days, the vomit had no fæculent odour.

Mr. Dunn saw the patient and advised saline-injection and stimulation to sufficiently improve patient's strength, if possible, so that the abdomen might be opened under eucaine and the peritoneal cavity washed out. The condition of patient was so bad that nothing else could be done. A pint and a half of saline was injected under the breasts and an attempt made to administer some per rectum through a soft catheter which, however, would not pass through the stricture.

Mr. Dunn thought that the peritonitis was possibly due to a perforated gastric ulcer. He said that when perforation occurs from a rectal stricture either immediately above the stricture or by ulceration of the cæcum, fæces are extravasated, the peritonitis is intense and death usually results in 36–48 hours. The amount of fluid present and the apparent succussion splash suggesting air and fluid free in the peritoneal cavity were considered to point rather to perforation of stomach than low down in the great intestine. Patient only lived a few hours after admission, the pulse becoming progressively worse.

Post-mortem.—A rectal stricture, apparently venereal, was found, some four or five inches long. Its lumen was about the size of a lead pencil. The wall of the gut was much thickened and the surrounded areolar tissue converted into thick fibrous tissue. The surface of the structure showed some bridles of fibrous tissue running in various directions and there were several pits present, one of which communicated by a very narrow channel with a large abscess lying between the rectum and the uterus. This contained a quantity of thick pus, of a greenish colour, and had very little odour. The abscess had apparently ruptured into the general peritoneal cavity, causing patient's death. There was no free gas in the peritoneal cavity.

Erosion.

This paper was read before the Dental Society on Feb. 14th, by Mr. J. A. DONALD, and received the Society's Prize.

MR. PRESIDENT AND GENTLEMEN,—I propose treating this evening of a few facts and theories concerning what is admitted to be one of the most remarkable affections to which the teeth are liable. Erosion is remarkable in that, in the investigation of its etiology it has defied the efforts of the most able and painstaking observers to come to any definite conclusion as to its causation.

It is on this account, I think, a subject which might well receive some thought and consideration from the members of this society. I have, therefore, tried to bring together, and will place before you for discussion, some of the points which seem to me to be of most value and interest to us as members of the dental profession.

The word erosion, which comes from the latin, rodere, to gnaw, means a gradual eating away or corrosion of any substance. In the dental sense we use it to describe that condition arising from the wearing of a tooth, mainly effected by causes other than mechanical friction, in contra-distinction to wearing by friction. If wearing is caused by contact with a foreign substance, we call it abrasion, if by an opposing tooth, attrition.

Erosion was first noticed by John Hunter in 1778. He described two diseases of the teeth. The first he called "Decay by Rottenness," which is the dental caries of the present day, and the other, "Decay by Denudation," which we now call erosion.

In the early part of the last century, Joseph Fox, in the lectures which he delivered in this hospital, described the same affection under the heading, "The Removal of the Enamel by the denuding process."

Let me first describe a typical case, then we may consider the various theories which have been, from time to time, advanced, to account for the phenomena of erosion.

A patient comes to us presenting upon the labial aspect of the front teeth one or more shallow saucer-shaped depressions which may affect only the enamel, or may extend into the dentine. The enamel is almost invariably unaltered in colour, it may be of an opaque whiteness, but the dentine is frequently, though not always, discoloured to a brownish tint, light in the early stages, but growing darker as the process of destruction becomes further advanced. The dentine also becomes more translucent in consequence of calcification of the protoplasmic contents of the dentinal tubes. It has been stated by some writers that neither the enamel nor the dentine alters in consistence. This statement should be modified, inasmuch as the dentine becomes somewhat harder than normal owing to this calcification. The surfaces of the excavations are smooth, hard, and highly polished, and frequently the dentine is exceedingly sensitive to the touch of an instrument, and the pulps susceptible to thermal changes. There is, however, apart from this, no pain. Cementum may, in rare cases, be the first tissue attacked. This is probably only the case when it has become exposed by recession of the gums.

Erosion, then, may be defined as a gradual molecular disintegration of the dental tissues, having a tendency to the formation of saucer-shaped cavities with smooth, hard, surfaces. The edges of the cavities are generally smooth and even. In well calcified teeth they may be sharp, but more often they are rounded off.

If a section be cut and examined under the microscope, the dental tubes and enamel prisms will be seen to end abruptly upon the eroded surface as if they had been cut across; a condition totally different from that which we find in dental caries, the enlarged and breaking down tubes of which we are all so familiar with. The enamel presents a granular appearance, the brown striæ of Retzins, and the transverse striæ of the prisms being well marked.

The form which the cavities take may vary considerably, for instance, there may be:—1. A simple shallow depression, round, oval, or sometimes irregular in shape, the deepest part usually being nearest the cervical margin. 2. A continuous horizontal groove, near to the gum margin, regularly and smoothly made, as if produced by a file; or 3. The destructive process may attack several points on the surface of the tooth, simultaneously, these afterwards coalescing to form a large cavity. When the cavities are deep, and retain particles of food in them for prolonged periods, softening of the previously hard surface takes place, germs appear, and erosion gives place to ordinary caries. The softening is preceded by a roughening of the surface, due to the suspension of the polishing process.

Erosion occurs more frequently in the upper, than in the lower jaw, and is often confined to one side of the mouth. Although generally found attacking the front teeth, and the labial aspect, it has been seen on the lingual and approximal surfaces, and also on bicuspids, and even on molars. The central and lateral incisors are generally accepted as being the teeth most often affected, and this point I will have occasion to refer to later, when speaking of erosion as distinguished from abrasion. It is seldom, if ever, met with before middle age, and the mouth is often singularly free from caries.

I have said above that erosion forms shallow cavities; it may, of course, however, go on until the pulp is endangered. When this happens, nature reacts to the stimulus, and makes an endeavour to protect that important structure, and secondary dentine is deposited about the pulp end of the fibrils involved in the eroded area. Occasionally the eroding process takes place more rapidly than the formation of secondary dentine; when this is the case, the pulp becomes exposed and inflammation of that organ ensues. But generally the process of destruction is slow, and the circumstance is favourable to the deposition of adventitious dentine, which, for the same reason, is usually well formed structurally. Thus the pulp is saved, but the process may go on steadily, until that part of the crown which is above the site of the erosion may be entirely removed.

The surfaces left in these cases generally look more or less forwards, owing to the labial aspect being first attacked, and therefore more affected than the lingual. The upper and lower teeth are some distance apart when the mouth is closed, thus differing from attrition, in which they would be in contact.

This form of erosion has been described by many writers as "chemical abrasion." It is of rare occurrence, and commencing on the incisors, spreads to the canines, but very rarely reaches the bicuspids. The dentine of repair formed is usually like ordinary dentine under the microscope, but in naked eye appearance it is of a darker colour, and it is of great hardness.

A very interesting case has been described by Mr. Bell, the secondary calcification being quite transparent. He says of it:—"When I first saw these teeth they had exactly the appearance of having been most accurately filed down at the edges, and then perfectly and beautifully polished, and it has now extended so far that when the mouth is closed the anterior edges of the incisors are nearly a quarter of an inch asunder. The cavities [pulp cavities] of those of the upper jaw must have been exposed but for a very curious and beautiful provision; they have become gradually filled by a deposit of new bony matter, perfectly solid and hard, but so transparent that nothing but examination by actual contact could convince an observer that they were actually closed. This appearance is exceedingly remarkable, and exactly resembles the transparent layers which are seen in agatose pebbles, surrounded by a more opaque mass."

Sometimes, instead of secondary dentine being formed the pulp may undergo an intrinsic calcification, a clear, amber-like mass being produced. Yet another form of erosion has been seen, in which the greater portion of the labial enamel, or even in some cases the enamel over the entire crown of the tooth becomes slowly and evenly removed, as if due to a form of atrophy. This condition depends, no doubt, upon a general maldevelopment of the enamel.

The rate of progress of erosion is, as I have already incidentally mentioned, slow, as a rule; but it is exceedingly variable. As examples of this, we may notice two cases. In one, the progress made in the wasting away of the teeth was so rapid that in two years from the commencement the remains of the upper centrals were separated from the lowers, when the mouth was closed, by nearly three-eighths of an inch, both upper and lower teeth being affected, and the bicuspids also involved. In another case, the incisors only were eroded, and the space between the uppers and the lowers did not exceed one-eighth of an inch. This case had been going on for seven years.

The time elapsing from the commencement in the enamel until the dentine becomes exposed is said to range from two to twenty years. The rate at which the disease extends depends upon the intensity of action of the exciting cause, the susceptibility of the teeth, and is perhaps indirectly influenced by the health of the patient. Frequently the eroding process, after having proceeded steadily for a certain time, becomes stationary; and after a long period no further change is visible. This seems likely to be the case in patients whose surroundings have undergone a change for the better, their general health improving, and the secretions of the mouth being altered, *i.e.*, an acidity giving place to the normal alkalinity of the buccal fluids. The exciting cause is removed or suspended. Against this notion, however, it is urged that erosion occurs with equal frequency in the mouths of robust people, enjoying excellent health.

The cause of erosion has not yet been satisfactorily explained. I am not going to try to explain it, but intend merely to review the various theories which are held on the subject.

It is said to be predisposed to by the gouty diathesis, being frequently found to occur in patients affected by that malady. This theory was proposed by Dr. Darby in 1892, and corroborated the following year by Dr. Perry, who, by experiments made on himself, demonstrated the fact that erosion was capable of being arrested by anti-gouty treatment. Gout may be due to heredity, or improper food, too much beer, and too little exercise in the fresh air. Patients suffering from gout, whether it be due to too good living (rich man's gout), or poor living (poor man's gout), can often predict an attack by a feeling of sensitiveness which they have in their teeth. Gout produces a constitutional acidity of the blood, uric acid particularly being present. This acidity is imparted to the secretions of the mouth, and so causes erosion.

It is sometimes impossible to diagnose erosion from abrasion; the cavities may simulate each other so closely that we are unable to say which affection we have to deal with without a reference to the cause thereof. We may have as guides only the position of the cavities and the cause, and this latter may not be apparent. In a case such as grooving on a tooth, generally a bicuspid or molar, in which the cause is sufficiently obvious, as a band or wire of a denture exerting constant pressure on the tooth, we have no difficulty, and pronounce the case to be one of abrasion without hesitation; but if no mechanical cause can be discovered, we generally put it down to erosion, after having excluded, of course, the possibility of caries.

So the questions have arisen:—What is erosion? Does it exist, or is it merely a form of abrasion? The result may be the same, the agents producing that result are distinctly different.

Mr. Salter considered that erosion and abrasion were not essentially different. He argued that the anatomical conditions are the same, and that the two affections frequently co-exist in the same mouth, and even in the same teeth. "Food and the act of mastication," he said, "may occasion friction on any part of the crown of a tooth, and will attack any part which is predisposed to it by faulty structure or damage." He would, therefore, have preferred erosion and abrasion to be classed together under the name of "surface wear," and held that both are due to mechanical friction, but admitted that solvent

fluids might assist in the process. He gave as a predisposing cause an inherent softness, and hard brush and gritty powders, and hard food as exciting causes.

Most writers consider however that there is sufficient difference between erosion and abrasion to justify the use of the distinctive terms, and regard each as a separate affection.

For purposes of comparison it will be necessary to say a few words about abrasion. It is essentially a condition of wasting of tooth substance due to mechanical causes, and is sometimes ascribed to friction from too energetic application of the tooth-brush used in a transverse direction. The upper canines and lower bicuspids are the teeth usually affected, owing to their prominent position in the arch; and the grooving produced is said to be deeper on the left side than on the right, the brush being held in the right hand. This may or may not be true. For example, I have seen a case recently in which there are equally deep grooves on both sides of the mouth. This patient uses his tooth-brush in his left hand. Personally, I do not think that one side receives greater friction than the other. Erosion proper, on the other hand, shows a preference for the incisors; but this fact is not accepted by all. Bödecker gives the teeth in order of susceptibility, as follows:—canines, bicuspids, incisors, and molars, giving the incisors quite a secondary place. His reason is, that the canines are often the first teeth to suffer from recession of the gums. Recession of the gums certainly does precede erosion in some cases; *i.e.* in those cases in which it occurs below the normal level of the gum margin. Erosion does not commence under the gum, but if the gum overlies the cavity, this is caused by an hypertrophic inflammation of that tissue, set up by the irritation caused by the cavity.

The main point is that wasting of the teeth occurs sometimes in positions which could not easily come in contact with any substance which could rub against them to any extent; and, moreover, the cavities may be of a very irregular shape, which also goes to show that it is not a mere mechanical effect. Abrasion cavities are usually of a more decided V-shape than those of erosion.

Thus, excluding mechanical friction as the primary cause of erosion, it would perhaps be wrong to say that it has nothing to do with it. Friction may act as an accessory agent, by helping to deepen the erosion cavity, or erosion might possibly, on the other hand, secondarily affect a depression which had been started by the tooth-brush.

Erosion is of common occurrence among some seals, particularly the sea-lion (otaria jubata). This circumstance has been made use of to further exemplify the fact that erosion can be produced independently of mechanical means. But Mr. Coleman has suggested that in these animals the wasting, which is often present as a circumferential grooving, may be caused by the stones, sand, and such like substances which they are known to be in the habit of taking into their mouths, in which case this instance becomes a simple case of abrasion, and therefore not available as evidence.

Erosion is said to be dependent upon faulty tooth structure due to some cause acting during the period of calcification; after much the same manner in which the effects of mercury, stomatitis, or other disease, produce honeycomb, or hypoplastic markings on the teeth. Disturbance of the normal nutrition of the tooth germ taking place, an area is formed deficient in lime salts, which therefore is more easily acted upon, than the rest of the tooth, by solvent fluids. Against this theory it is argued that erosion does not occur upon developmental lines, as would be expected; that is, if the agency producing the defect was at work, say about the fourth or fifth year, the affection should be confined to, or at least start in the parts of the teeth which were forming at that period, the erosion on the laterals occupying a position nearer to the cutting edge of the tooth than on the centrals. But erosion often occurs in a line parallel with the gum margin, and bearing no relation at all to the points to which calcification would have extended at any particular time.

Taking a step back in the history of erosion, we find that Hunter thought it was a disease originating in the tooth itself, and that it occurred independently of any external agency, constitutional condition, or circumstance occurring during after life, his reason for holding this view being that it attacks certain teeth rather than others, and is often confined to one particular tooth, or even to a part of that tooth. On the contrary, however, those who advocate a constitutional cause say that erosion has a tendency to spread from tooth to tooth.

More recent writers abolish all such ideas as disease already existing in the dentine or enamel, and ascribe erosion to the action of solvent fluids.

An argument against what may be termed the vital theory is to be found in the fact that erosion may occur in dead teeth. Dr. Parmly found erosion on natural teeth fixed on plates, and used as artificial substitutes. The question which arose, of course, was whether the erosion had not occurred while the teeth were still alive, but if so, they would probably not have been used. It seems more natural to suppose that sound teeth were always selected for prosthetic purposes, when that method was in use. As it has happily gone by the board, it cannot be made use of for purposes of further investigation, but the matter is regarded as being definitely settled that erosion does occur in dead teeth. Dr. Millar also demonstrated erosion in an ivory inlay, which he inserted in a tooth, itself the subject of extensive erosion. This recurrence in a material foreign to the situation would point to the cause being some influence external to the tooth. Most writers seem now to be agreed as to the chemical factor, namely, an acid condition of the fluids of the mouth, the action of the lips keeping the fluid in motion, and thus aiding the solution of the tooth substance.

Mr. Sevill says, "Enamel, containing no physiological elements, is incapable of pathological change or of any process resembling ulceration. Waste can only be due to external agencies." The question of the source of

the acid which causes erosion has been made a subject of much discussion. Erosion occurs in localized positions, therefore probably the source of the acid is a local one. Two theories on this point are in vogue. One, that the labial mucous glands pour forth their secretion in an excessive amount and altered form, namely, acid. The mucous membrane of the lip is frequently in a swollen and hyperæmic condition in connection with erosion, and an abnormal condition of the glands would be a natural accompaniment to this state of affairs. Normally, the mixed secretion of the glands of the mouth is an alkaline fluid consisting of water, mucin, ptyalin, and inorganic salts, among the most important of which is sodium phosphate. Under certain chemical conditions, as in the presence of carbonic acid, sodium phosphate parts with one atom of sodium and combines with one atom of hydrogen to form acid sodium phosphate. This acid sodium phosphate is then the active agent; it acts upon the calcium phosphate of the enamel, converting it into a salt ($CaHPO_4$) which is fairly soluble in water. Thus the process of disintegration is started.

The other theory as to source of acid is that it is formed by fermentation of food and mucus, the acid in this case being probably one of the varieties of lactic acid. Particles of food tend to lodge in certain situations at the necks of the teeth, where there is often a slight recess, adjacent to the gum margin. Fermentation of this food soon produces sufficient acid to dissolve a thin film of enamel. These then are the local sources. Each of the views has its adherents, and which one is to be accepted remains an open question. Probably both are correct and both might be adopted, a double source of acid being quite a reasonable supposition. To those might be added acids from a more general source, such as food or medicine, which may also aid the process.

When the first film of enamel is removed the surface left becomes polished by the action of the lips and tongue, and the flow of the saliva. This surface again, in its turn becomes dissolved, and repolishing takes place. Thus we get the alternate effects of denudation and polishing, which produce and maintain a smooth, hard surface.

In support of the acid theory we have Dr. Black's experiments with currents of dilute acid directed against teeth. By this means he produced marks of erosion similar to those seen clinically. Mr. Underwood also has shown that the enamel of some teeth at the seat of erosion is granular and unduly susceptible to the action of acids. He also described an appearance in enamel like interglobular spaces; and this has not been demonstrated in any teeth other than those effected by erosion.

On the other hand, Prof. Wedl found erosion on teeth in an ovarian cyst, the fluid in which is always alkaline. Some difference of opinion exists as to the existence, or not, of a zone of partial decalcification surrounding the erosion cavity. Bödecker holds that there is such a zone, and this partially decalcified area would explain the hypersensitiveness of the dentine, the terminations of the fibrils being exposed by solution of the surrounding lime salts. But as the surface of an erosion cavity is very hard and the dentine is translucent, it is in this situation probably hypercalcified rather than decalcified.

It may not be out of place if I here say a few words about the composition of enamel, bearing directly as it does upon the subject in hand. Mr. Tomes states that it has been usual to suppose that enamel contains three and a half to five per cent. of organic matter, and that this was estimated by loss on ignition. He undertook a series of experiments, and found that after enamel had been long dried at 300° F., it still contained some four per cent. of water in close chemical combination, and that which had hitherto been regarded as organic matter was water in combination with salts.

It has been long recognised that water takes a part in the composition of enamel. Joseph Fox, to whom I have already alluded as being a lecturer at Guy's about one hundred years ago, gave in his book an analysis of enamel made for him by Pepys, as follows:—Phosphate of lime, seventy-eight per cent.; carbonate of lime, six per cent.; water of composition and loss, sixteen per cent. He showed that enamel which had been heated until it was apparently quite dry, still contained about eight per cent. of water. He made no mention of cartilage.

Later, Berzelins and other chemists, found other salts to be present in enamel in varying quantities, and also, they thought, organic matter; but this, as I have said, has been disproved. The figures of the various analysts, of course, do not agree, but the point of interest lies in the fact that water was shown by Pepys to be a constituent of enamel in actual combination. Enamel then being solely an inorganic material, it is perfectly obvious, gentlemen, how it may be removed by an acid. But when the dentine is reached by the process of erosion, there is more than simple inorganic matter to be dealt with, there is the organic constituent of the dentine. How does this become dissolved? In caries, we say, germs peptonise the organic constituent of the matrix, it thus becomes softened and gets washed away. In erosion we have no germs, for if there were germs and acids which caused the disintegration of the tooth, it would not be erosion at all, but ordinary dental caries. For is not caries a molecular disintegration of tooth substance effected by solvent fluids, and aided by germs, and erosion is essentially different from caries? Chromogenic bacteria may perhaps play some subsidiary part in producing the discolouration; this can, however, I think be quite satisfactorily accounted for by pigmentary granules, which have been taken into the mouth with the food, becoming lodged in the exposed ends of the dentinal tubes. So we may exclude germs from taking any great part in the causation of erosion.

It seems pretty certain that only two existing causes can be at work, a chemical, and a mechanical factor.

We have seen how the solution of the inorganic material is effected by acids, but this will not apply to the organic, the collagen. If a tooth be placed in acid

of the strength which might exist in the mouth, the dentine would not become dissolved, but only rendered soft and flexible. Possibly, the material, consisting of collagen and elastin, which remains after the solution of the mineral elements, might be worn away by the many substances with which it comes in contact. Even in people who never use a tooth-brush or toothpick, the slight friction caused by particles of food, or the action of the tongue and lips would be enough to dislodge what remains of the dentine, after it had been softened by acids. But a more plausible theory has been advanced to account for the solution of the organic elements; this has been attributed to the action of alkaline sulphocyanides of ammonium and potassium. The saliva of patients presenting erosion is said to contain an increased amount of these salts; and it has been found that by submitting teeth to the action of a solution of sulphocyanide of potassium, a condition similar to erosion could be produced. The collagen is dissolved, and also a chemical action takes place between the sulphocyanides and the salts of the dentine, whereby salts are produced, which are freely soluble in water.

Many other theories as to the cause of erosion have been advanced. Time will allow me to but briefly mention some of these.

It has been suggested that erosion is caries tending to undergo spontaneous cure, or in other words that it is a form of arrested decay; but this is very unlikely. None of the teeth, which we know for a fact to have been carious, and which have become eburnated, show the least resemblance to erosion.

Mr. Bland Sutton associates it with defective development, and with diseases of bone. He found it frequently to occur in animals in connection with rickets, mollities ossium, and similar diseases.

Erosion has been found in the rudimentary tucks of the female Asiatic elephant. The tusks are not bathed in saliva, so it could not be due to a solvent fluid. It might be of parasitic origin, the larvæ of an insect being found adherent to the tusks in these cases.

It is also suggested that erosion may be a sort of absorption. In the case just cited, of the elephant, this might be so, as it is a functionless organ which is attacked. This is an example of "the survival of the fittest," or the tendency of all rudimentary and functionless organs to disappear. But, wherever absorption occurs, the characteristic absorbent organ with its multinucleated osteoclastic cells and lacunæ of Howship can be demonstrated. On the exposed surfaces of erupted teeth there is no possibility of an absorbent organ existing, so this view is untenable.

Lastly, within recent years another theory has been proposed by Dr. Znamensky, of Moscow, who talks of erosion as "cuneiform defects," and holds that enamel plays no part in the process. He believes that the organic matter, being first brought into solution, swells, and bursts off the enamel; the inorganic portion is then shed.

Hunter described cases in which cavities were suddenly produced by the breaking down of the enamel, which had become unsupported, the external layer of the dentine, or the innermost layer of the enamel being first disintegrated. This, of course, could only be due to an internal cause, and would coincide with his theory that erosion is a disease inherent in the tooth itself. But the formation of an erosion cavity is generally a gradual process. We often see cases in which the erosion is confined to the enamel, the dentine not having been reached; and erosion is now believed to be due to external agencies, the reasons for which I have mentioned.

This being so, the dentine could not be acted upon first. The agent which produces softening of the dentine could not obtain access to that tissue before the enamel was removed. Again, we have the fact that when enamel becomes undermined by caries, and gives way, there is generally a rough overhanging edge left.

Would not the same thing occur in erosion if due to this cause? But erosion cavities are characterised by their smooth, sloping edges, undercuts being rare.

In conclusion, we may sum up briefly by making a selection from the conflicting theories which abound. The most likely explanation of the phenomena of erosion seems to be that it is due primarily to an abnormal condition of the buccal fluids; the exciting cause being an acid, and perhaps, to some extent, an alkaline salt. The action of these two agents probably alternates, the acid acting while predominant, the alkali in the intervals.

Aids to the process may be some modification of tooth structure, rendering the tooth unduly susceptible to the action of external agencies, and a certain amount of mechanical friction. The friction, which is only a minor and accessory agent, is supplied by the movements of the lips, tongue, etc.

Under no treatment so far devised is the complete arrest of erosion assured. Filling does not arrest erosion. If a gold filling be inserted, it will be found after a time that the wasting of the tooth is still going on, and that the filling stands out above the level of the enamel, unless, indeed, other means to check the process, such as removal of the cause, have been adopted at the same time.

The cause being an acid condition of the buccal fluids, an alkaline mouth wash would be indicated. In this capacity milk of magnesia is recommended. But, as we have seen, erosion might occur without the presence of acid, in which case this treatment would not avail. Perhaps this explains the intractability of some cases. Those who believe the labial glands to be at fault, practise the application of caustics to the mucous membrane.

General treatment for the regulation of the secretions would be of value, as anti-gouty treatment for gouty cases.

If the eroded spots are hypersensitive, this condition should be relieved by the application of escharotics to the exposed fibrils. For this purpose zinc chloride is one of the most useful agents for erosion in front teeth. The cavity should be swabbed out with a solution of cocaine or aconite before applying the zinc chloride, as otherwise the application may be followed by great pain, which soon, however, passes off.

Zinc chloride may be used as a solution by allowing a crystal to deliquesce in the cavity, or better, as a paint, combined with mastic.

It rarely happens that erosion occurs in inconspicuous positions, but in such cases nitrate of silver may be used. I only now, gentlemen, wish to thank you for your kind attention during the reading of this paper. I am afraid it is rather a come down, in view of the very excellent papers which you have recently had read; but I hope it has not bored you too much.

Passim.

In another column will be found the annual report of the Clubs' Union Committee. It reveals a most unsatisfactory progressive embarrassment from a financial point of view, which obviously cannot be allowed to stand. Nobody who has spent even but a few months at Guy's will consider the possibility of permitting a lasting crippling of our various forms of athletics from a want of such funds as have hitherto been available; to such the theory which connects a healthy body with an active mind is shown so practically true by a dozen illustrations in the best men of every year, that to the great majority the only point for discussion lies in the method of obtaining the necessary means. It is not, however, an altogether uncommon occurrence, we believe, for parents who send their sons to the hospital to object to the Clubs' Union subscription, on the grounds that they send them up to work and not to play; there may even be a few amongst the first year's men who think likewise, and to whom a steady application to books and work seems the only high road to success. That some very few do arrive at their ambition's goal by these means alone is true, but how much greater is the number whose health gives way. That the scholastic life of a hospital is intimately bound up with its recreations is an axiom to most of us, perhaps trite and well worn, but its truth is not everywhere so apparent as it should be. Moreover, it is not only whilst at his hospital that an athlete shows his power of adding honour to her name at work and play; in after life, to whatever corner of the earth his luck may take him, he will find that the one as much as the other will work for his happiness.

The best method of restoring the financial position is by no means so easy to arrive at as it might seem to be at first sight. The natural course which appeals to one is that the annual subscription should be raised—say by one guinea; the objection to this, raised by those who have most to do with the collecting of the money, is that the number of subscribers would so fall off as to more than negative the increase obtained from those who still remained; this objection coming from those who are in the best position to judge, must be given its due weight, but it is difficult to believe that a man's selection of a hospital would be influenced by the small extra expense which this plan would involve, or that he would object to becoming a member on these terms when he saw what an influence in hospital life the games possess. Other suggestions less obvious, but perhaps more capable of producing an effective increase in the income have been made, and will no doubt be carefully considered in committee; amongst them is the suggestion of our correspondent that gate money should be systematically charged at the matches played at Honor Oak Park. Our Rugby team has certainly achieved a position in which it should be able to get good clubs to come and play on our ground. Why not a Welsh match at home? A few good matches of the kind, and the support, which the neighbourhood seems already inclined to give to the ground, would be assured.

The balance-sheet this year shows that the gate receipts have advanced with a bound during the last year. This is excellent, in showing the increasing popularity of the club, but even if the improvement be maintained for the next year or two, the increased income thereby acquired cannot be expected to do more than a part of the work in filling up the gap. It is more easy to meet the position by a combination of plans than by a single stroke of genius. The plan which appeals to us most as likely to prove a powerful and effective auxiliary is the abolition of the present system of including the Guy's Hospital Reports amongst the benefits bestowed upon students in return for the payment of the composition fee. It is a moral certainty that not more than 25 per cent. of the students read their Reports in any but the most perfunctory manner. They are accepted certainly, and carried off to adorn the bookshelves and give a studious air to the room, for they are neatly bound and prettily illustrated with coloured plates of skin diseases and sarcomata; but it is to be remembered that each little collection of five Reports costs the Clubs' Union twenty-five shillings, and that

their withdrawal would mean another £100 a year to that institution. The small minority who really desire to read the reports and who would derive some benefit from them, might acquire them by personal enterprise, whilst the majority would only suffer in that they might have to find some less instructive and soothing picture book with which to amuse the rising generation. Obviously the presentation of Reports should cease.

The simple abolition of the composition fee is also surely worth considering. Under the present system one year will show as an especially prosperous one, when really this is due to a large proportion of men having paid a composition fee. The next year perhaps men will prefer to pay yearly, with an apparently disastrous falling off in the revenue as a result. Moreover, such a measure would ensure another two guineas from many men without giving fright to freshers. One rumour which is in the air that the Staff should be appealed to for further subscriptions suggests a course which cannot, we think, be too strongly condemned. At present, the Medical School contributes £100 a year, which is an indirect subscription from the Staff, and a substantial one. A club, constituted as is ours, should surely be self-supporting, and any further call for charity is to be deprecated as unbusinesslike and unhealthy. Men cannot expect to get the many benefits offered by the Club without paying for them; it shows but a poor spirit to be persistently calling for help. Should anyone be seized with brilliant inspirations let him not keep them to himself.

The complete results of the Intermediate M.B. list this July are not yet available, but already such brilliant successes have been achieved as to make it one of our best years for the last half-century. To secure three scholarships and three gold medals, with a qualifying excellence for the fourth, is indeed a thing to be proud of, and we offer our most hearty congratulations to Messrs. A. B. O'Brien, R. W. Allen and C. M. Wenyon for the honours which they have brought both to themselves and to Guy's.

Mr. O'Brien takes the Anatomy and Chemistry Scholarships and Medals, whilst Mr. Allen takes the corresponding prizes in Materia Medica. Mr. Wenyon has made a great fight for the last remaining medal, and is to be congratulated on obtaining the qualifying marks.

The resources of New Zealand, which has given us so many good men already, are evidently not yet exhausted, for both Mr. O'Brien and Mr. Allen hail from that colony. The former is the present captain of our Rugger Team, a point which gives some additional force to our remarks elsewhere on the subject of the Clubs' Union.

It may not be without interest to note the winners of medals and scholarships for the past few years. It will be seen that the year 1892 is the only year which parallels the present; previously to that one has to go back to the year 1859, when Dr. Hilton Fagge secured all the scholarships. In Anatomy we have three winner of scholarships since 1882. In that year the late Dr. Anderson secured it; in 1895, Mr. C. H. Fagge; Mr. O'Brien being the third. Medals were obtained by Mr. Lane, 1879; Mr. Wenyon, 1871; Mr. Parkin, 1886; Mr. Steward, 1892; Mr. Walker, 1895, and Mr. Rowlands, 1901. Of Chemistry Scholarships we have obtained nine since 1879. The winners were: Adeney, 1879; Parry-Price, 1880; Wheelton Hind, 1881, Washbourn, 1883; Starling, 1885; Hopkins, 1890; Havard, 1891; Steward, 1892; O'Brien, 1902. Physiology Scholarships have been won by Parry-Price, 1880; Starling, 1885; Harnett, 1893: and corresponding Medals by Steward, 1892; Collins, 1894; Northcott, 1897; Bolus, 1901, and Wenyon, 1902. Materia Medica Scholarships have been won by Nolan, 1892; Philip-Turner, 1895; Hilton, 1896, and Allen, 1902. The Medical School have every cause to congratulate themselves on this sign of a vigorous and well-directed teaching in its various branches. In our next number we hope to publish a complete list of pass and honours.

It was indeed unfortunate that the first of Mrs. Cosmo Bonsor's garden parties should

have fallen on a wet day. The occasional patches of bright weather in the sombre grey of this English summer day were utilized to the full in exploring the charming grounds of Kingswood Warren, and when the rain again drove the guests indoors, there was always the hope that it would be fine later. But the day was destined to be wet, ear-marked in nature's programme as an earth washing day, so the amusements of the afternoon became exclusively indoor. But what mattered it if it rained? Was there not a bewitching band and an ideal floor for dancing? Was there not a billiard table, with a blushing marker, and a covered squash-racket court abandoned to ping-pong? Then when the rain had ceased, the stables, and the rose garden, and perhaps a venturesome trip to the church. The guests of the second day had ideal weather, but even with the improved climatic conditions it is impossible that they could have enjoyed the day more keenly than did the others. The Treasurer has added one more stone to his monument of popularity.

The place of honour in this number of the Gazette is given to an excerpt from Addison's Treatise on Medicine. Everybody knows everything about appendicitis nowadays; even the lay journals give hints by which a diagnosis may be obtained, though perhaps at a sacrifice of the King's English; few, however, know that Addison appreciated many years ago much, if not all, of our present knowledge of the subject. We are indebted to Sir Samuel Wilks for the hint that has led to the republishing of this article, and to Dr. Pitt, who has added considerably to the interest and value of the paper by supplying references to certain specimens of the diseased organ in our museum which must date back some ten years before the publishing of Addison's famous treatise.

It is refreshing to find a surgeon whose thoughts are occasionally diverted from scalpel and forceps, and a physician whose mind can shatter the fetters of the pharmacopœia. When such a man exists, he usually awakens the desire that more members of the most learned profession would give their opinions on collateral subjects. As an example we need only mention the lecture which Sir Samuel Wilks delivered before the Hampstead Scientific Society on May 12th. Taking as his subject the "Relation of Science to Art in reference to Taste and Beauty," he read a most masterly paper on this interesting and much debated question. In the end he confessed that his own views were hardly determinate; that, beyond the conviction that beauty has its foundation in utility, in its widest sense, he was still amenable to argument on many points. The lecture has been published in pamphlet form, and although it lacks the aid of Sir Samuel Wilks' persuasive oratory, it is still a most interesting and thoughtful paper. Anyone who has the smallest interest in the subject should most certainly read the lecture, which may be obtained through any bookseller. We hope Sir Samuel Wilks will not allow this to be the last communication that he makes on Science in its relation to Art.

Drs. John Wade and F. Gowland Hopkins have achieved the distinguished honour of the Doctorate in Science of the University of London. There is small need to mention that this degree stands out pre-eminent in science, and every Guy's man knows that it would be impossible to find in London two men who were better worthy of the honour. We offer them our heartiest congratulations.

We have to congratulate Dr. Eyre on his appointment to the post of Bacteriologist to Guy's. To many of us he is best known from his past work in the gloomy halls of the Eye Out-patients, where he was ophthalmic assistant, but in the wider world without, his work at Charing Cross Hospital and his contributions to medical journals have given him a firm footing amongst rising bacteriologists. Guy's has of late lost two of her bacteriologists—one by emigration, the other, and chiefest, by the hand of death—and there is plenty of scope for Dr. Eyre, who will, we have no doubt, be a worthy successor to those who have gone before.

This year there was no competition for the Beaney Prize in Pathology. There are many

prizes in the medical world to be won which are never competed for, or which are sought by one man only, who does a monotonous walk over; even in go-ahead America we believe this is equally the case. Whether in the self-destroying modesty of their hearts good men judge that there are better who will render it useless for themselves to try, or whether it is that these prizes are not sufficiently advertised, it is hard to say. Perhaps it is mere slackness. In Guy's, and during the long series of ward appointments, it is not so hard to find a reason. For a man to work systematically with a view to competing for the prizes of his year, it is necessary for him to sit down at the beginning of his course and form his plans for his career from its outset. Did men do this, it would not be always easy to stick to their arrangements, for sometimes examiners plough the best (*vide* the College Midwifery), and sometimes appointments are sought in vain. But the fact is that men, with a few exceptions, have not the foresight if they have the ambition. A man's ambition at the commencement of hospital life is generally too lofty and noble to be anything but vague. And to men who have not made their preparations long before, a notice suddenly appears that a prize is to be competed for next month. They have been caught with no oil in their lamps, and go away feeling somehow that they have been done out of something. True, it is their own fault, but there may be those who, if the competitions were advertised three months before, would sit down then and do their best. It cannot be that the news of another prize uncompeted for passes through a hospital without heartburnings from more than a few who were eligible, and with a little reminding there should surely be no more such throwing away of opportunities.

SIXTEEN months after their return to England the members of the Staff of the Imperial Yeomanry Hospital are to receive their war-medals. Guy's will be strongly represented in the gathering at Devonshire House where Her Majesty the Queen has graciously consented to present them. That the hospital should be bidden Godspeed by the Heir-Apparent, and should be received on its return by the Queen, is indeed an honour, and it is to be expected that all its members will show their appreciation by their attendance.

A NEW guardian angel has come to watch over us as we sit at food, and the old and honoured term Battenitis must be relegated to a place amongst the dusty records of the past; we fervently hope that no fresh term will have to be invented with a similar import; at present all seems well. Let no one murmur anything about new brooms.

IN the last number of the GAZETTE, we jested mildly anent the overture of the stomach. The Rev. Elwyn Lewis, a Doctor of Music, has taken us at our word, and sent us the following. If read slowly, in a good light, with free exhibition of stimulants, a vast number of brutal and ruthless puns will reveal themselves. Ugh!

> The "overture" of the stomach, from which the lady mentioned in last week's GAZETTE is suffering, may sym-phony to many, but to the father who is anxious for his daughter to Liver bit longer, and does not wish her to Diaphragm-pant dyspepsia, it seems to offer a spleen-did opportunity for medical skill.
>
> In considering the case from a musical point of view, har-mony persons are there who will treat it correctly? One will reveal his Spohr-city of imagination by copying Bellini; another will be Abt to Lizst-en Auber-much to what the Berlioz-ld professors were ac-Costa-med to say; a third will Offenbach his Verdi-ct against the Mozart-istic practitioner, while a fourth will Schubert little claim to be heard, through not seeking to diminish Schumann suffering.
>
> In certain disorders of the stomach the medical man will Bar solid food in order to ar-Rest the Czerny-ng process for a Time, but in this case, our readers will Note, the treatment is quite different, and the GAZETTE has Clef-erly shown a Pauer-ful grasp of the matter by calling in a Doctor of Music who, knowing that an "overture" is an "opening movement," prescribes for the patient that she shall finish with the Tonic.

ONE of the hard-working little band of heroes who live on the ground floor of the College amongst the blackbeetles, and who wander forth day and night with little bags into the Borough, brings to our notice a new view of our work which was presented to him by one of his lady assistants. He was called one evening to a

mansion in Page's walk and found Mrs. Gamp in attendance. Before leaving he informed the patient that he would order her some medicine; the lady was, however, one of those unfortunates to whom medicine spells nastiness, and resolutely declined to have anything to do with it. This elicited the following persuasion from Mrs. G.: "Oh, yes, yer must 'ave the medicine; they does this all for nothing, yer know, but they likes yer to buy something, and it's only threepence!"

Case for Diagnosis.

(For Solution see p. 328.)

Patient, a boy of ten, was brought to the front surgery in the evening, suffering from a swelling of the face. Five days previously he had complained of a sore throat and had been treated elsewhere. His condition apparently remained the same until the evening before he was brought to the hospital, when his face began to swell. When seen his temperature was 100°, pulse weak, soft and rapid (120). The face was very swollen and the glands beneath the jaw on the left side enlarged and brawny. The cellular tissues of the face were infiltrated, the eyelids of both eyes being puffy and discoloured, the lower of the left eye presenting a hæmorrhage about the size of half a crown. There was no history of a blow on the face. Pus was exuding from the nostrils and a bead of pus was on the inner canthus of the left eye. The breath was very offensive, the mouth thickly furred, and the left tonsils excavated and gangrenous. The urine was free from albumen and of normal colour. The specific gravity was not taken owing to the small quantity available. The general condition of patient was dull and lethargic. He had had no rash on his body nor was there any evidence of peeling.

The Society of Medical Phonographers.

This Society will hold its next Annual Shorthand Examination early in May, 1903. Two prizes will be offered, each of the value of £5, one for first-year students and one for students of more than one year's standing. The competition will be open to any Registered Medical Student in the United Kingdom who has not taken a first prize at one of the Society's previous examinations. It will be held simultaneously in London, Edinburgh, Dublin, and at any provincial medical centre in the United Kingdom at which not fewer than three Candidates shall offer themselves.

Intending Candidates should send in their names as early as possible to *Dr. P. G. Griffith, Bonhams, Farnborough, Hants*, who will furnish them in return with a detailed Prospectus of the Examination.

The *latest date for receiving entries* will be April 15th, 1903.

Revised Syllabus for L.D.S. Examination.

By R. P. Rowlands.

Anatomy.

All the bones, but the small bones of hand and foot are not important.

All the anatomy of the head and neck, but only an elementary knowledge is required of the brain, cord, eye, and ear.

An elementary knowledge sufficient to understand the physiological actions of—

(*a*) All the thoracic and abdominal viscera, especially heart, lungs, stomach, and intestines.

(*b*) The large joints, especially the knee, and sterno-clavicular.

(*c*) The muscles producing the main movements of the body, especially the muscles of the upper limb, and those used in dental operations.

(*d*) Course of large vessels and nerves.

Physiology.

Foodstuffs.—Nature of proteids and gelatin, fats, carbohydrates, salts, and water. Digestion and absorption of these. *Composition of* milk, meat, bread, butter, potatoes, soup, beef-tea.

Salivary glands.—Structure at rest and in activity, nerves, composition and uses of saliva, ferments organised and unorganised. Mastication and deglutition.

Stomach.—Structure, gastric juice and its uses, vomiting. Pancreas: structure, secretion and its uses.

Liver.—Structure of lobule, circulation, bile-ducts, gall-bladder. Glisson's capsule. Bile and its uses. Glycogen.

Intestines—structure, valvulæ conniventes, structure of villus; secretion, actions; peristalsis, colic, diarrhœa; naked-eye appearances of different parts; course of food from mouth to anus; defæcation.

Absorption of food and course into the blood of each variety.

Lymph and chyle — receptaculum chyli, lacteals, thoracic duct.

Respiration—internal and external—structure of lungs and trachea, pleura; movements of chest and how produced; nerves and nerve centres of respiration; changes in larynx during breathing; cough; capacity of lungs, tidal air, etc., dyspnœa, apnœa; differences between inspired and expired air, and between arterial and venous blood; diffusion of CO_2 and O_2, condition in the blood. Ventilation; structure and uses of nasal mucous membrane.

Circulation—Blood.—Constituents, corpuscles, plasma, coagulation; structure of heart and blood-vessels; actions of heart, cardiac cycle, peripheral resistance, blood-pressure, velocity of blood; pulse, pulse tracing, velocity, rate; bleeding from vein, artery and capillary; nerves and nerve centres for heart and vessels. Aids to circulation (1) respiratory movements, (2) valves, (3) contraction of muscles; fœtal circulation.

Nervous system.—Structure of nerve cells and nerve fibres, reflex arc, reflex action, examples; structure of white and grey matter (of brain and cord); paths of sensory and motor impulses; uses of different parts of brain and cord.

Excretion by kidneys.—Structure, urine composition, urea, micturition.

Excretion by skin.—Structure, sweat, uses.

Excretion by lungs, intestines, etc.

Body heat.—Production, loss, regulation, warm and cold blooded animals, temperature.

Muscles.—Structure, uses as producers of movement and heat; phenomena of contraction.

Special Senses.—Brief account of the mechanism of each special sense.

SURGERY.

Inflammation.—Phenomena, results; acute abscess, its wall, pus, ulceration, cellulitis, sloughing, gangrene, necrosis, boils, carbuncles, styes, sinus, fistula; general characters of fever.

Wounds.—Kinds, wound infection micro-organisms and their action; sapræmia, septicæmia, pyæmia, erysipelas, tetanus, aseptic treatment of wounds.

Repair.—Various methods in detail.

Hæmorrhage.—(1) Primary kinds, natural arrest, and repair of vessel; artificial arrest; arrest of bleeding from mouth, tongue, tonsil, lip, tooth-socket, nose and varicose veins; (2) Reactionary; (3) Secondary, causes, treatment, effects of hæmorrhage, treatment of anæmia; hæmophilia and other bleeding diseases; scurvy.

Syphilis acquired and congenital (thoroughly).

Aneurysm and cirsoid aneurysm.

Tumours.—(*a*) Innocent; (*b*) Malignant; i. Connective tissue; ii. Epithelial; Especially—epithelioma, carcinoma, sarcoma, rodent ulcer, fibroma, myxoma, osteoma, wart, and nævus. *Cysts*—hydrocele, sebaceous, and dermoid.

Diseases of the Tongue.—Wounds, acute glossitis, chronic superficial glossitis, thrush; Ulcers of tongue and mouth; simple, mercurial, tubercular, syphilitic, malignant; Tumours—Excision of tongue.

Diseases of the Salivary Glands.—Ranula, salivary calculus and fistula; mumps; tumours.

Ganglion, eczema, ringworm, scabies, impetigo, cystitis, chilblains, lupus.

Diseases of bone.—Periostitis, osteitis, necrosis, acute infective necrosis, or osteomyelitis, caries, rickets, growths, osteoma, exostoses (ivory and cancellous), sarcoma (central and peripheral), odontomata, excision of jaws.

Syncope and shock.

Concussion and compression of brain, meningeal hæmorrhage, fractured base.

Fractures.—Signs, treatment, process of healing, treatment of fractures of jaws, dislocation of lower jaw.

Anæsthetics. — Choice, risks, foreign bodies in air passages, laryngotomy, tracheotomy, cut throat, foreign bodies in œsophagus.

Cleft palate and hare-lip.

Diseases of lymphatic glands, septic, tubercular, and malignant, and Hodgkin's disease.

Adenoids, nasal and nasopharyngeal polypi.

Diseases of the maxillary antrum.

Tonsillitis, diphtheria, retro-pharyngeal abscess, alveolar abscess, fixation of lower jaw, (causes and treatment).

Diseases of joints, especially tubercular.

Otitis media and its complications.

Ophthalmia. Keratitis.

Epulides.

Results of section of a nerve trunk.

Scald of larynx, œdema of glottis.

Burns.

Hernia.

Hæmorrhoids.

Books recommended are—

Moore or Ashby in Physiology.
Walsham or Ashby in Surgery.
Gray or Ashby in Anatomy.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Wooldridge Memorial.

DEAR SIR,—It might be inferred from the admirable appreciation of Washbourn by J. J. E. B. which was published in the last number of the GUY'S HOSPITAL GAZETTE that Guy's had failed to remember the genius of Wooldridge. That is not so, for in the GAZETTE for November 21st, 1891, page 274, will be found an account of a meeting held at Guy's to raise a memorial to Wooldridge. In the number of December 5th, 1891, page 292, is the first list of subscriptions, in that for May 28th, 1892, page 168, is the second list of subscriptions and the announcement that the committee decided to place a bronze tablet in the portico of the Anatomical Buildings. In the GAZETTE of June 25th, 1892, page 200, is the final list of subscriptions. The bronze tablet was considered worthy of admission to the Royal Academy and was exhibited in 1893. In the GAZETTE for July 8th, 1893, page 246, the reader will find a description of it, and on page 247 is an eloquent leaderette on another form of memorial, namely, the publication of Wooldridge's collected papers. The bronze memorial has been on the walls of the entrance hall to the Pathological Museum for the past nine years. Further, there is awarded to Guy's students a Wooldridge Memorial Prize for Physiology. It is also interesting to note that in the GAZETTE for December 1st, 1894, there is an account of a tablet put up to the memory of Wooldridge in the chapel of the school at Cranleigh.—Yours faithfully,

W. H. W.

Guy's Hospital Clubs' Union.

Sir,—When I was last at Guy's I was sorry to hear that the excellent institution the Clubs' Union was in straightened finances. I have no doubt that the present students will soon find a means of setting this right without impairing the usefulness of the various clubs, active participation in which keeps the men fit while at the hospital, and teaches them much which is valuable to them afterwards.

As an outsider, I should like to suggest that the Union might without any impropriety meet some of the expenses of keeping up its ground at Honor Oak Park by more freely admitting the public to watch matches and asking them to pay for the privilege. If the football and cricket clubs are as popular as they were in my time a little making known of the matches they are going to play ought to bring a good "gate." The chief drawback to a large attendance seems to be the want of shelter in case of rain. Would it not be a profitable investment to erect a covered stand? Two or three hundred pounds thus spent ought soon to be repaid. It seems poor comfort to suggest to one in straightened circumstances to spend more money, but I can't help thinking in this case such an expenditure would be judicious. I wish I could offer to build the stand myself for the benefit of my alma mater, but the public have not sufficiently appreciated the medical skill I gained at Guy's to make it possible. There may be others interested in Guy's more favourably situated.—I am, yours truly,

H. E. C.

The Hereafter.

Sir,—I have read "Spero's" article with much interest and the letter of R. H. F. in your last issue under the above heading. Surely your correspondent misses the point. For the purposes of an anonymous article there can be no objection to putting the "hard and unpleasant facts" boldly. The incentive to work hard is furnished by two desiderata, the one the pleasure of doing, the other of excelling. The second motive is the stronger, and from the day we enter upon our education a motive that is always lauded by our teachers. In medical work in what does "excelling" consist? Nine times out of ten in careful critical examination of clinical problems, not in profound knowledge, the essence of success being accuracy of diagnosis.

Is a man to be debarred from the just reward of his toil and care for fear of hurting the feelings of rivals less careful and energetic than himself? I fail to see that "Spero" has shown himself more than an averagely competent man by his treatment, and as for his diagnoses, these may be arrived at by any man who will take the care and trouble he exhibited. Let us consider two or three of his cases in the light of R. H. F.'s "mutual help" suggestion. The lad who was deaf and had been abandoned as incurable, "Spero" should have acquiesced or returned him to the "other physician" with a gentle note of suggestion. There is a certain proverb about an elderly relative and an egg. Clearly "Spero" should have "minimised" his "hated rivals'" failure to remove the polypi from the woman's nose by neglecting to do so himself. To have discovered a dilated stomach where others had failed (of course, because they had not looked for it) was, I suppose, in the worst of taste. To be blunt—Where does the patient come in? As "Spero" is probably a Guy's man and a gentleman, it is unlikely that he made any comment to the patients on the work of his predecessors. Deeds are more eloquent than words. It is the old story of the survival of the fittest, and I agree with "Spero" that a man is morally bound to do his best. Competition levels up the standard of work. R. H. F.'s advice, if followed, would bring all men down to a "dead level" that an unattainable ideal of "mutual help and association" might be approached. The public have a right to ask a man's best, and any curiously altruistic consideration that tends to make that man withhold his best, makes him to that extent a dishonest craftsman.

P. G.

Guy's Hospital Clubs' Union.

ANNUAL REPORT, 1901–1902.

The Council of the Clubs' Union beg to present the Tenth Annual Report of the progress of the Union, together with a statement of the receipts and expenditure for the year ending 31st March, 1902.

The membership of the Union continues to increase, the increase this year being 83, as against 66 last year. The total membership of the Union is now 2,196, of whom 2,061 are Life Members, 94 Subscribers, and 41 Patrons. The continued support accorded by the Governors of the Hospital and by old Guy's men is especially gratifying to the Council, in view of the financial difficulties that have arisen.

We again venture to point out to old Guy's men who have not paid their guinea subscription for Life Membership the advantage of having their names and addresses in the Clubs' Union Blue Book, which is a useful directory, and is much used by Members who wish their patients, when away from home, to be looked after by Guy's men.

The Council last year drew attention to the fact that the financial position of the Union was far from satisfactory; they now regret to report that, as will be gathered from what follows, the state of affairs has become most serious.

The net income for the year, deducting balance from last year, amounts to £1,409 12s. 6d. Last year the net income was £1,621 5s. 11d., and the previous year it was £1,755 8s. 1d. The income is, therefore, £211 13s. 5d. less than last year, and £345 15s. 7d. less than it was two years ago. This diminution, which amounts to nearly 20 per cent., is more than accounted for by the

falling off in the amount received from donations and subscriptions, which is £280 5s. 6d. less than it was last year, and £417 19s. less than it was two years ago.

The total expenditure this year amounts to £1,543 3s. 3d. This, when compared with last year's figures, shows an apparent saving of £115 3s. 6d. This figure, however, is deceptive, because the grants to the Constituent Institutions have of necessity been this year cut down to a very large extent, with the result that several of the Constituent Institutions are already unavoidably in debt. Moreover, the amount paid in rates and taxes has increased this year by £66 0s. 5d., and will be further increased next year.

Comparing now the income with the expenditure, it will be seen that the expenditure exceeded the income by no less than £133 6s. 9d.; there has been, therefore, a direct loss of £133 6s. 9d. on the last year's working, which has absorbed the previous balance of £116 16s. 8d., and has resulted in a deficit of £17 12s. 8d.

The Council, therefore, beg to call the attention of their successors to the above figures, and would suggest that the new Council should forthwith devise some means of dealing with the situation.

During the past year the financial position of the Union has constantly engaged the attention of the Council, and various projects for its improvement have been under discussion. That no definite proposal has been made is in some measure due to the great loss the Union has sustained by the lamented death of the Treasurer, Dr. Washbourn. At the moment when he was stricken down by illness, Dr. Washbourn, at the request of the Council, was engaged upon a careful enquiry into the Union's finances, and the result of his investigations are available for his successor. The Council desire to express their appreciation of the great services Dr. Washbourn rendered to the Clubs' Union, and to all movements connected with the recreation of the Students of the Medical School.

The best thanks of the Council are due to the Officers of the Constituent Institutions, to the Auditors, to Mr. Croucher, and other Members of the School Office Staff for their able assistance.

(Signed) LAURISTON E. SHAW,
Chairman.

Statement of Receipts and Expenditure from 1st April, 1901, to 31st March, 1902.

To Receipts.	£ s. d.	£ s. d.
Balance at Bankers	116 8 5	
Petty Cash in hand	0 8 3	
		116 16 8
Annual Subscriptions	241 10 0	
Composition Fees for Life Membership	591 8 6	
Subscriptions from Patrons ...	9 7 0	
Subscriptions for Gazette and Reports	141 18 0	
		984 3 6
Grant from Medical School, 1901... ...		100 0 0
Grant from Dental School, 1901		15 0 0
Rent from Tenants		90 0 0
Rent from Lockers		15 2 6
Year Book Advertisements		74 4 9
Sale of Railway Tickets		58 6 8
Deposit Interest		20 1 1
"Gate" Receipts		42 4 0
Special Grant from Medical School for Enlargement of Year Book		10 10 0
		1526 9 2
Deficit due to Bankers		17 12 8
		£1,544 1 10

By Expenditure.	£ s. d.	£ s. d.
Grants to Constituent Institutions—		
Athletic Club	37 0 0	
Christian Union	3 2 0	
Cricket Club	14 11 6	
Debating Society	6 0 0	
Dental Society	6 7 0	
Football Club (Association) ...	18 8 10	
Guy's Hospital Gazette	207 5 0	
Guy's Hospital Reports... ...	155 15 0	
Lawn Tennis Club	15 13 4	
Physical Society	18 3 10	
Rifle Association	12 0 0	
Students' Club Grant	141 1 8	
Students' Club Rent	118 10 9	
Swimming Club	2 8 8	
		756 7 7
Field Current Expenses		248 3 5
Field Rent Account		224 10 0
Management Expenses—		
Printing and Stationery ...	2 13 6	
Secretarial Expenses	34 14 3	
Postage	2 1 2	
Insurance	1 7 0	
Production of Year Book ...	97 7 0	
		138 2 11
Railway Ticket Deposit Account		66 13 4
Rates and Taxes		107 16 4
Petty Cash Expenditure		1 9 8
Petty Cash in hand		0 18 7
		£1,544 1 10

Audited and found correct,
R. P. ROWLANDS.
C. J. PINCHING.
FRANCIS J. STEWARD, *Hon. Sec.*

From the Gazette's Special Pathologist.

T. D. H., Aberystwyth.—This sputum contained numerous clumps of tubercle bacilli.

T. R. A., Chadwell Heath, Essex.—This sputum contained pus and a considerable number of tubercle bacilli, many of which were arranged in small clumps.

PATHOLOGIST.

Sport.

Cricket.

GUY'S v. ELTHAM.

This match was played at Eltham on Saturday, July 19th, resulting in a win by 7 wickets and 11 runs. Through a misunderstanding, our opponents did not arrive until 2.30. Thanks to some fine bowling by Morgan, 6 wickets for 31, they were dismissed for 135. The runs were knocked off by Bookless and Morres in a very bad light, the former carrying his bat for a faultless innings. Scores:—

ELTHAM.

J. C. Wood, c Collins, b Morgan	45
C. A. Pitt, c & b Hicks	25
W. Young, b Morgan	5
A. S. Johnson, b Foster	4
A. S. Jackson, b Morgan	4
Haywood, b Morgan	12
C. R. Stamp, b Morgan	8
Capt. Logan, c Tolhurst, b Wyatt	2
W. MacFarlane, b Morgan	16
G. A. Atkinson, b Foster	8
K. Johnson, not out	0
Extras	6
Total	135

GUY'S.

J. Bookless, not out	53
H. D. Wyatt, c Atkinson, b Johnson	5
E. A. Collins, b Johnson	15
F. Morres, b Johnson	50
R. Willan, Jun., not out	1
Extras	22
Total	146

E. Morgan, E. L. Norton, A. M. Tolhurst, M. G. Louisson, A. L. Foster, and J. T. Hicks did not bat.

GUY'S v. WELLINGBOROUGH MASTERS.

This match resulted in a draw. Guy's made 94 for the first wicket; afterwards Morres and Norton played excellent cricket, and we declared for 8 wickets, leaving our opponents two hours and twenty minutes to get the runs. This they almost accomplished, owing to a splendid effort by P. A. Fryer. We were very kindly entertained, and hope such an excellent match will result in a permanent fixture. Scores:—

GUY'S.

H. D. Wyatt, st. Mules, b Tovey	104
J. Bookless, c P. A. Fryer, b Robinson	38
E. A. Collins, b Williams	10
F. Morres, c Edwards, b Simpson	84
R. Willan, Jun., b Williams	7
E. L. Norton, b Fryer	43
H. H. Carter, not out	10
J. T. Hicks, b Williams	1
H. H Moyle, b Williams	0
Harris, not out	10
Extras	13
Total	320

S. A. Piper did not bat.

WELLINGBOROUGH.

P. A. Fryer, c Wyatt, b Harris	130
F. N. Bird, c Collins, b Harris	26
C. H. Tovey, run out	33
H. B. Simpson, c Wyatt, b Harris	35
D. P. Williams, c Collins, b Wyatt	27
C. C. Monkhouse, lbw, b Wyatt	12
W. W. Robinson, not out	10
J. W. Dyson, not out	8
Extras	10
Total	293

W. H. Edwards, H. W. Mules, and A. N. Other did not bat.

CRICKET SEASON, 1902.

The Fixture Card was strengthened and improved, and the results have been fairly satisfactory, the team winning six matches, lo-ing five, and drawing seven. Barber heads the averages with 43·55 for twelve innings, and this is, considering the wickets, the best season he has had with us; his batting has been of incalculable value. The only cup match we played in, against Middlesex on a bad wicket, ended in disaster.

BATTING.

(Six innings or more).

	No. of Inns.	Times not out.	Most in Inns.	No. of runs.	Average.
H. Barber ...	12	1	102	479	43·55
H. D. Wyatt	17	1	150*	492	30·75
J. Bookless ...	15	6	53*	237	26·33
H. M. Langdale	6	1	58*	124	24·8
F. Morres ...	17	1	84	467	22·94
E. Morgan ...	13	1	55*	189	15·75
E. A. Collins	16	1	53	204	13·6
M. G. Louisson	7	2	34	62	12·4
E. L. Norton	15	2	43	152	11·69
R. Willan, Jun.	11	1	27	93	9·3
A. L. Foster...	7	2	5*	13	2·6
(Less than six innings).					
H. H. Carter	4	3	28*	51	51
R. Willan, Sen.	2	—	41	41	20·5
S. C. Bowle ...	3	—	35	44	14·66
H. M. Tolhurst	5	1	9	40	10
J. T. Hicks ...	5	—	27	30	6
L. G. Davies	4	—	14	16	4
H. Gibson ...	2	—	1	1	·5

Also batted:—Harris, 10*; G. N. Bartlett, 7; J. Munro, 5; C. H. Miller, 2: H. Moyle, 0.

* Signifies not out.

BOWLING.

(Ten wickets or more).

	Wickets.	Runs.	Average.
L. G. Davies	15	100	6·6
H. D. Wyatt	42	654	15·57
E. Morgan	28	447	15·96
J. T. Hicks	11	202	18·36
A. L. Foster	18	501	27·833
(Less than ten wickets).			
H. Barber	3	54	18
R. Willan, Jun.... ...	9	180	20
J. Bookless	8	225	28·12
Harris	3	90	30

Guy's Hospital Rifle Association.

The 1902 Season has necessarily been a poor one, notwithstanding that the great bugbear, slackness, which helps to mar the prospects of so many of our clubs, has for the most part been absent.

The difficulties have been on the financial side. Whereas other hospitals secure a grant sufficient to ensure them at least one match or practice a week, and a sufficiently enticing prize list at the close of the season, we have to struggle through with a grant that will not even enable us to pay off the ordinary annual liabilities of the Association, such as are due to the U. H. R. A. and N. R. A.

It speaks uncommonly well for the keenness of the members and supporters of the Association, that we were able to hold a fairly respectable prize-meeting, and to retail at 6d. per packet ammunition for which we have to pay over 1d. per round. Such an outburst of generosity cannot be expected to continue unsupported for any length of time, and unless the Clubs' Union can see their way to putting the Association on a better financial footing it will be unfortunately necessary to disband it at a moment when its prospects seem unusually well assured.

Out of 4 matches during the season, we have lost 3 and won 1. We were unfortunate in losing both the Inter-Hospital events; St. Thomas's and St. Bart.'s tied for the Armitage Cup, having beaten us in three out of the four shoots. At Bisley, the same two hospitals again tied for the "Hospital Cup," beating us by only 10 points. The Cup was awarded to St. Bart.'s in the count out.

Date.	Match.	Result.
May 14	1st shoot for Armitage Cup	Total 392
	Simultaneous Match "A" Co. Team, 2nd V.B. Welsh	Lost
„ 28	2nd shoot for Armitage Cup	Total 420
	Simultaneous Match with Malvern College	Lost
June 11	3rd shoot for Armitage Cup	454
„ 18	4th shoot for Armitage Cup	443
	Simultaneous Match with Eastbourne College	Won
„ 30	Whitgift Grammar School	Lost
July 9	G. H. R. A. Prize Meeting—Newton-Pitt Cup won by G. C. F. Robinson.	
„ 17	Bisley Cup	Lost

Appointment.

SMITH, WALTER H. M., M.R.C.S., L.R.C.P. Lond., has been appointed Public Vaccinator for the Norwood District of the Croydon Union.

Papers by Guy's Men.

An Explanation of the Cause of Inequality of Pupils in cases of Thoracic Aneurysm. By R. Cecil B. Wall, M.A., M.D. Oxon, M.R.C.P. Lond., and E. W. Ainley Walker, M.A., M.D. Oxon.

A Clinical Lecture on Diabetes By W. Hale White, M.D., F.R.C.P. Lond.—*The Clinical Journal*, July 16th.

On the Innervation of the Urinary Passages in the Dog. By C. Herbert Fagge, M.S. Lond., F.R.C.S.—*Journal of Physiology*, July, 1902.

On the Acetone Series of Products in connection with Diabetic Coma. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S.—*The Lancet*, 19th and 26th July.

A Case of Rheumatic Hyperpyrexia, followed by symptoms resembling those of Di seminated Sclerosis. By William Allen, L.S.A., and James W. Russell M.A., M.D. Cantab., M.R.C.P. Lond.—*The Lancet*, 19th July.

The Pathology of Certain Growths about the Lower Jaw. By J. H. Targett, M.S. Lond., F.R.C.S.—*Transactions of the Odontological Society of Great Britain* for May, 1902.

Solution to Case for Diagnosis.

Patient was sent to the South-Eastern Fever Hospital, where he died the next day. The cultures taken on admission showed the Klebs-Loffler bacillus, and the post-mortem revealed extensive hæmorrhages. The case was therefore one of hæmorrhagic diphtheria.

Marriages.

HODGSON—PIMM.—At St. Peter's, Staines, June 18th, Victor James Hodgson, L.R.C.P. Lond., M.R.C.S., D.P.H. Camb., of Westcliff-on-Sea, Essex, to Patty, only daughter of James Morris Pimm, of the Mansion, Staines, Middlesex.

NICHOLLS—GEE.—On the 10th inst., at St. John the Baptist's Church, Knighton, by the Rev. James Jeakes, M.A., Prebendary of St. Paul's Cathedral, late Rector of Hornsey, assisted by the Rev. C. Page Eden, M.A., Vicar, Francis John Nicholls, M.B., B.C. Cantab., M.R.C.S, L.R.C.P., of Ellerslie, Eltham, second son of Edward W. Nicholls, of 62, Queen's Gardens, Hyde Park, to Mabel Violet, third daughter of H. Simpson Gee, J.P., Knighton Frith, Leicester.

Death.

JORDAN.—On July 14th, at the Knoll, Newport, Monmouth, Henry Martyn Jordan, F.R.C.S. Eng., aged 37.

ED.—A. P.

Contents.

	PAGE
Muscular Atrophy: Clinical Lecture by Dr. Bryant ...	329-338
A Nursing Guide	338
Pass List	338
Passim	339-342
From the Gazette's Special Pathologist	342
Guy's Hospital Clubs' Union	343
A Sussex Elysium	343-344
Correspondence: The Hereafter	345
A Curious Case	345
Nursing News	345
Reviews	346-347
Sport: Cricket—Guy's 3rd XI. v. Christchurch "A" ...	348
Appointments	348

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold will be One Shilling and Sixpence.

Guy's Hospital Gazette,

AUGUST 30, 1902.

Muscular Atrophy.

CLINICAL LECTURE BY DR. BRYANT.

Gentlemen,—I propose to-day to demonstrate and to lecture to you on a case of Muscular Atrophy at present under my care in Miriam ward. Mr. Bevers has made a very excellent and careful report, and I will first of all read to you an account of the case based on his notes.

Lilian S., aged 9, admitted April 11th, 1901, for wasting of the legs and hands. Her mother states that when she was born forceps had to be used. Although she was a small child she was considered strong and healthy and could walk at the age of nine months. She then had a bad attack of bronchitis, and to use the mother's words, "was taken off her feet until she was fourteen months old." She suffered several times from bronchitis during the next three years, and when she was four she had an attack of whooping cough and was ill for three weeks. When she recovered she was unable to walk. Her mother said "that she did not seem to know how to take her steps." On account of this she was taken to the Orthopædic Hospital in Oxford Street, where a diagnosis of infantile paralysis was made. She was ordered to wear boots with iron supports.

The mother described both feet and legs as being wasted as far up as the knees at this time, the right being more affected than the left, and she also stated that at times the child used to fall down, her knees giving way without any warning. She was quite unable to get about without her boots. When she was five and a half she had scarlet fever, and at six and eight years attacks of measles. Fifteen months ago the mother noticed that both the child's hands and body appeared to be getting thinner. At times she complained of aching pain in the feet and could not walk as far as she used to. On several occasions she suffered from tonsillitis. The mother also stated that the wasting and weakness of the hands and body had been getting worse since they were first noticed. At times she has complained of pain in the right foot, passing up the right side into the right arm, and also of headache. She has of late also been unable to hold or pick up things as well as other children, and she writes slowly and in a peculiar manner. When doing nothing she allows her hands to hang limp in front of her. During sleep she has been noticed to clench her hands. She has never had a fit and has always had perfect control of her urine and fæces. She has never had any sign of chorea.

Both her parents appear to be strong healthy people. The father states that one of his brothers suffers from weakness and wasting in his arms and legs, and that he has a sister who has had fits of an epileptic character and that another of his sisters is affected with heart disease. Both his mother and father are well, and with the exception of his brother mentioned above, no history of muscular wasting in any other member of the family can be obtained, and the same applies to his wife's family. He

has been the father of nine children, of whom five are living, and are all strong and well with the exception of this little girl. He further states with regard to his brother that he was late in learning to walk, that at the age of three weakness commenced in the feet without any apparent cause, there being no history of any acute illness at this time. Wasting of the muscles followed the weakness, and at the age of ten the hands were affected in the same manner with both weakness and wasting. From this time the trouble has been progressive in character. He is now thirty-nine years of age, and the wasting has slowly extended from the feet as far as the knees and from the hands to the forearms. At an early date he was able to get about with the help of a stick, later he had to resort to crutches. At the present time he is quite helpless as to his hands and feet and wears pads on his knees, dragging his feet and legs behind him as he moves along, whilst his hands are so weak that he is quite unable to hold his short crutches, and to remedy this iron hooks have been attached to his forearms and with these he grasps the crutches. He appears to be strong and healthy in other respects without wasting of his body, upper arms or thighs. To resume the clinical history of the patient we are now considering.

Condition on admission.—She is a healthy, intelligent, bright looking child. At times she lets her hands fall limply in front of her, and if they are raised from the bed a condition of wrist-drop becomes apparent. There is marked wasting of the thenar and hypothenar muscles of both hands, and also of the interossei. With regard to the forearms, they are neither very large nor very small; perhaps, on the whole, there is a slight wasting. The muscles of the trunk do not appear to be much wasted, if at all. The scapulæ are rather prominent, and there is a slight spinal curvature in the dorsal region, with the convexity backwards, and a little lordosis in the lumbar region. She has full use of her arms and free movement of the hands, with a very fair grip. The deltoids and scapular muscles are not wasted, nor are the facial muscles. She holds a pen like other people, but writes very slowly. As she lies in bed the feet are extended, there is slight talipes varus and marked wasting of the muscles of the legs below the knees. There is no wasting of the thigh muscles or of the glutei. None of the muscles are abnormally hard, and there is no history of the muscles having previously been large and hard. When she first gets out of bed she cannot walk, and can only just stand, but she soon recovers and gets about fairly well. The gait is of a high stepping character. There is slight genu valgum.

The sensory functions appear to be normal. There is no loss to touch. Rain, heat or cold, and all these forms of sensation can be appreciated and differentiated.

The knee-jerks are absent. There is no ankle clonus, wrist-jerk nor elbow-jerk. The plantar reflex is present, and is a flexor response. The abdominal, epigastric and scapular reflexes are present. The pupils react to light and to accommodation.

The left leg is weaker than the right, but she can lift both legs off the bed against a fair amount of resistance. The movements of the knee and hip-joint are good.

There is well marked wrist drop, but she has a fair grip in both hands. The movements of the thumbs are rather weak. There does not appear to be any weakness of the upper arm muscles, or of the shoulder or scapular muscles. There is no spasm, tremor or incordination. Slight fibrillation has been noticed.

Electrical reactions.—With the Faradic current there is no response in the thenar and hypothenar muscles, nor in the interossei, with the exception of the third left dorsal, in which a slight contraction can be obtained. The flexors and extensors of the wrist respond normally, as do the shoulder, upper arm, scapular muscles and muscles of the face. The small muscles of the feet, the peronei, and anterior tibial muscles do not react, but the calf muscles, the thigh muscles and the glutei react normally. With the galvanic current there is no reaction in all those muscles which do not react to the Faradic current, but in the other muscles K.C.C. was greater than A.C.C. No changes in the optic disc, retina, nor choroid. The circulatory,

respiratory and abdominal systems do not present any abnormal changes.

The urine is acid, light in colour. S. g. 1030, and contains no albumen, sugar, pus nor blood.

The most noticeable feature of this case is the muscular atrophy which has involved the feet, legs and hands. There are also well-marked changes present in the electrical reactions of the muscles which show most atrophy, for they react neither to Faradism nor to galvanism. In first of all considering the diagnosis of this case, it is therefore evident that a careful analysis must be made of all the symptoms and signs of the various diseases which are characterised by muscular atrophy in order to see with which type it coincides.

Muscular atrophy may result from lesions of:

1. The anterior cornua.
2. The anterior nerve roots.
3. The nerves.
4. The muscles themselves.

The following is a list of the several diseases:

1. *Anterior cornua.*
   - *a.* Acute anterior poliomyelitis.
   - *b.* Subacute and chronic poliomyelitis.
   - *c.* Progressive muscular atrophy.
   - *d.* Amyotrophic lateral sclerosis.
   - *e.* Diffuse myelitis.
   - *f.* Hæmatomyelia.
   - *g.* Syringomyelia.
2. *Anterior nerve roots.*
   - Compression by caries.
   - ,, growth.
   - ,, hæmorrhage.
   - ,, pachymeningitis.
3. *Nerves.*
   - Injury.
   - Neuritis.
4. *Muscles.*
   - Pseudohypertrophic muscular paralysis.
   - Idiopathic muscular atrophy.
     - *a.* Erbs type.
     - *b.* Landouzy Déjérine type.
5. *Neuro-muscular.*
   - Tooth's peroneal type.

A certain amount of muscular atrophy may result from disuse, and may be associated with paralytic conditions due to lesions of the pyramidal fibres above the anterior cornual cells, *e.g.*, to lesions of the cortex, corona radiata, internal capsules, crura, pons, medulla or pyramidal tracts of the cord. The muscular wasting which results from such causes is never accompanied by reaction of degeneration or by a loss of the electrical reactions such as is found in this case.

Children not infrequently suffer from paraplegia as a result of cortical lesions at birth. It is distinctly stated by the mother that this child could walk when she was nine months old. It is not at all likely, therefore, that her present condition is in any way connected with an injury to the cortex at the time of the instrumental delivery. The loss of reaction of the muscles to Faradism and galvanism and the absence of knee-jerks also are points against a cortical or cerebral lesion.

The failure of certain of the atrophied muscles to react to either Faradic or galvanic stimuli has a most important significance, for in addition to excluding lesions of the upper neuron, it indicates that the cause of the trouble must be in the anterior cornua, anterior nerve roots or motor nerves, and practically excludes the possibility of a simple idiopathic muscular atrophy, by which I mean a condition of muscular atrophy due to changes in the muscles alone, the anterior cornua, anterior nerve roots and motor nerves being quite free from any pathological changes.

The possibility of infantile paralysis must be carefully gone into, on account of this disease having been diagnosed at the Orthopædic Hospital. The child was taken there soon after the attack of whooping cough, and the somewhat acute nature of the paralysis and wasting of the legs must have led to this diagnosis. The relation the disease appears to have to the attack of whooping cough has a most important bearing on the diagnosis, and I shall refer to it again when discussing the idiopathic muscular atrophies.

Infantile paralysis is an acute disease characterised by pyrexia, loss of power and rapid atrophy of certain muscles. The lesion which produces these symptoms is an acute inflammation of the anterior cornua.

The cause of the atrophy of the muscles is a destruction of the nerve cells in the anterior cornua, with a resulting degeneration of the corresponding motor nerve fibres. The onset is usually very acute, and in some cases may be described as sudden. It is accompanied by marked constitutional disturbances such as pyrexia, vomiting, restlessness, headache, and even convulsions. These symptoms may last for two or three days, but occasionally they are absent altogether. It is essentially a disease of late infancy. Three fifths of the cases which occur in early life are under three years of age. It rarely occurs before six months. Boys and girls suffer equally. It occurs much more frequently in the summer than in the winter. Epidemic forms, even, have been described in America. Over exertion, exposure to cold, and falls, appear to be exciting causes. Out of 214 cases analysed by Gowers, not one was found to have had any definite relation to an acute disease. Severe pain is often a well-marked initial symptom, more particularly in adults and older children. It is often a misleading symptom, and I have seen it more than once lead to a diagnosis of acute rheumatism. A careful examination will show that the joints are not involved. I remember some years ago when I was attending medical out-patients, hearing one of my fellow students ask the physician if there was not often a difficulty in distinguishing between infantile paralysis in the early stages and acute rheumatism. The reply was that there should be no difficulty. The very next case, however, which was examined, proved to be a child acutely ill with pyrexia and pain in the legs. The child was admitted to the hospital, the diagnosis being ?acute rheumatism ?infantile paralysis. After being a few days in the ward there was no doubt about the diagnosis, for loss of power and muscular atrophy had supervened, and it was clearly a case of infantile paralysis.

I have, attending at the Electrical Department, a child suffering from well-marked infantile paralysis who was seen on the second day after the onset by a specialist in nervous diseases. She was feverish and in acute pain and was considered by him to be suffering from rheumatism. A few days later she was seen by an obstetric physician, who, finding considerable loss of power in her legs was able to make the correct diagnosis of infantile paralysis. A few cases commence less acutely, the loss of power taking two or three weeks to develop. The paralysis is not progressive in this disease, but, on the other hand, rather retrogressive, as there is a tendency for a certain amount of recovery, except in a particular part or parts where the muscles rapidly waste. Disturbances of sensation, such as anæsthesia, analgesia, etc., are usually absent. The reflexes are lost in the affected parts.

In addition to the atrophy of the muscles, other trophic changes, such as the retardation of the growth of bone, may be noticed. Later on there is also a tendency to permanent shortening of the muscles, a condition which may lead to displacement and deformities. The sphincters are very seldom involved. The muscles supplied by the cranial nerves are very rarely affected.

Gowers divides the disease into four stages—

1. An initial stage of paralysis accompanied by fever, lasting from a few hours to a week or more.

2. A stationary period lasting for a week to a month.

3. A stage of "regression," during which the paralysis passes away, except from the parts where wasting occurs, the period lasting from one to six months.

4. A chronic stage during which the atrophy continues, and during which slight improvement occurs, but deformities develop.

I think you will be able to see from what I have told you about infantile paralysis that the little girl I have just shown to you is not suffering from this disease. There are several important points against such a diagnosis. First of all there is the absence of a history of any acute onset, then there is the distribution of the loss of power and atrophy; it is extremely rare to get both feet and legs and both hands affected as a result of infantile paralysis. Then there is the relation of this disease to the attack of whooping cough. I have already drawn your attention to the fact that in 214 cases of

infantile paralysis of Gowers' not a single case can be traced to the effects of an acute disease. Then there is the fact that the disease has definitely been progressive, the hands becoming affected several years after the feet and legs. This progressive nature of the disease is a very strong argument against a diagnosis of infantile paralysis, which is essentially a retrogressive disease.

Before passing on to the consideration of the causes of muscular atrophy, I will show you a well-marked case of infantile paralysis and compare it with the case you have already seen.

The following is a short history.—Winifred W., æt. 4½, was brought to the Electrical department for loss of power and wasting of the right arm. On July 30th, 1900, she was running and fell suddenly on her right side. She tried to save herself by putting out her right hand. On the following day the right arm was found to be powerless, and she was very feverish and ill. Wasting of the muscles soon followed. She never had much pain in the arm and there was never any loss of sensation. She was treated at the Children's Hospital, Great Ormond Street, for some time.

She came to the Electrical department on January 30th, 1901. There was marked atrophy of the deltoid, biceps and triceps and of the muscles of the forearm and hand. There was no loss of sensation. There was well-marked reaction of degeneration. The condition now is practically the same.

A few cases of muscular atrophy are due to subacute or chronic poliomyelitis. They are characterised by a much less rapid onset. Paralysis followed by atrophy of the muscles comes on gradually; if within thirty days, they may be termed subacute, and if from one to six months, chronic.

Cases of this kind are difficult to differentiate from chronic myelitis and from multiple neuritis. They occur most frequently in adults. The long period between the occurrence of the changes in the hands and the onset of the disease with weakening and wasting of the muscles of the foot and leg, and the age of the patient, are, I consider, the important points against the disease being of this particular nature.

The marked wasting of the thenar and hypothenar muscles is one of the changes which is first noticed in cases of progressive muscular atrophy. This is a chronic disease which is due to a degeneration of the anterior cornua of the spinal cord. The degeneration involves the ganglion cells and is accompanied by a degeneration of a similar character in the motor nerve fibres which come from the affected cells. Associated with this degeneration there is usually also a degeneration of the pyramidal tracts of the cord. Gowers writes, "I have not yet met with a single case of progressive muscular atrophy in which the pyramidal tracts are unaffected." He does not distinguish between progressive muscular atrophy and amyotrophic lateral sclerosis. As progressive muscular atrophy and amyotrophic lateral sclerosis are described as two different diseases in Dr. Taylor's Medicine, I shall, in order not to confuse you, discuss these two conditions separately.

Progressive muscular atrophy, then, is a degenerative disease of the anterior cornua first involving the lower cervical and upper dorsal regions of the spinal cord. It occurs more frequently in males than in females and it usually commences between the ages of twenty-five and forty-five. The youngest case recorded, that I know of, is one in which the disease began at twelve.

Weakness and wasting usually come on together, and the onset is insidious and gradual. Often no cause can be traced. The thenar and hypothenar muscles are usually first affected, and they may be followed by weakness and wasting of the muscles of the arm and shoulder. Fibrillary contractions are usually well marked. Faradic and galvanic excitability are usually both diminished, and there may be a partial form of reaction of degeneration. The reflexes are lost. There is no anæsthesia, and the bladder and rectum functions remain intact.

The age of the patient is a very strong argument against the disease being progressive muscular atrophy, for she has not yet reached the age of the youngest case recorded. The

commencement of the weakness in the feet and legs with the loss of knee-jerk is another point of importance.

Amyotrophic lateral sclerosis is a disease characterised by a degeneration of the anterior cornual cells and by sclerosis of the crossed pyramidal tracts. The anterior cornual cells are involved in the lower cervical and upper dorsal regions of the cord, and the crossed pyramidal tracts are involved, as a rule, throughout the cord. The disease usually begins in the hands and arms with wasting of the thenar and hypothenar muscles; fibrillary muscular contractions occur, and the electrical reactions are similar to those obtained in progressive muscular atrophy. In addition to these changes in the upper extremities, there are the symptoms produced by the lateral sclerosis, viz., loss of power in the legs with rigidity, exaggerated knee-jerks, ankle clonus, and extensor plantar response.

It is evident, therefore, that the little girl is not suffering from this disease. She is still too young; the disease in her case commenced in the legs, and the arms were only affected several years afterwards; and further, the condition of her feet and legs are obviously not due to a lesion of the crossed pyramidal tracts, for her knee-jerks are lost, there is no ankle clonus, no extensor plantar response and no rigidity, and then there are the altered electrical reactions.

The mode of onset, the absence of sensory disturbances, the normal condition of the bladder and rectum functions exclude the possibility of her condition having been due to a diffuse myelitis, for that disease is characterised by its acute onset with tingling and numbness, followed by a rapidly developing paralysis. All four limbs become paralysed, there is general anæsthesia, the muscles waste, the reflexes are lost, and there is retention of urine and involuntary passage of fæces. Death as a rule soon follows.

Hæmatomyelia or hæmorrhage into the spinal cord may be followed by muscular atrophy. It is distinguished from other diseases by the very sudden onset. The symptoms resemble those produced by acute myelitis. It would be quite impossible for hæmatomyelia to have produced such changes as you have seen in this little girl without also causing very marked sensory, trophic and visceral changes.

Syringo-myelia is another disease which may be accompanied by marked muscular atrophy. The term syringo-myelia is used to denote a condition of cavitation of the spinal cord. The cavities are often congenital, and they may be associated with a diffuse gliomatous condition. The two chief symptoms of this disease are loss of sensibility to pain and temperature, and muscular atrophy which may resemble in its characteristics progressive muscular atrophy.

The muscular atrophy is a result of the damage to the anterior cornua from the compression of the cavity and its adjacent gliomatous growth. The motor nerve cells are damaged or destroyed, the corresponding nerves degenerate, and the muscles they supply atrophy. The absence of the characteristic sensory disturbances, viz., the loss of sensibility to pain and temperature make it, I think, quite clear that she is not suffering from syringo-myelia.

Muscular atrophy may also be a result of diseases of the anterior nerve roots. They are not usually primarily affected but may be pressed on as a result of caries or growth of the spine, by meningeal hæmorrhage and by thickening of the meninges. In the case of caries and growth changes may be noted in the spine. Meningeal hæmorrhage comes on quite suddenly. They are all, however, characterized by shooting pains in the back, neck and arms. Anæsthesia, loss of reflex and reaction of degeneration may also result.

There is no evidence to even suggest that the anterior nerve roots are involved in the case before us.

There is no history of injury and it would be most unlikely for any injury to pick out just so many nerves as would correspond with the distribution of the weakness and atrophy.

The possibility of a multiple neuritis being the cause of the atrophy must be much more seriously discussed. The fact that all four limbs are affected, the curious high stepping gait, the wasting of the muscles, the changes in the electrical reactions, the onset after an acute disease, are all conditions which may be explained by a multiple neuritis.

Against a diagnosis of multiple neuritis is the curious way in which the disease has progressed. It is quite unlike a multiple neuritis to produce weakness and wasting of the legs at the age of three, and weakness and wasting of the muscles of the hands in the same patient between seven and eight, without any apparent cause or reason. And further, no cause for a multiple neuritis could be traced. In children a multiple neuritis is most likely to be the result of diphtheria. There was no evidence at all of the child ever having suffered from it, and further there was no history of fluid regurgitating through the nose, of nasal voice, or of squint, all conditions which are very commonly found in patients suffering from diphtheritic neuritis. The atrophy of the thenar, hypothenar and interossei, might suggest the possibility of plumbism, but there has not been, and there is no collateral evidence of such a condition. I consider, therefore, that we have not sufficient evidence to say the muscular atrophy is due to any ordinary multiple neuritis.

I must now pass on to the consideration of the various forms of primary and idiopathic muscular atrophies, diseases which are characterised by primary changes in the muscles themselves, the nerves and spinal cord being normal. The occurrence of a similar affection in another member of the family and the early onset of the disease are two very important diagnostic indications of some form of idiopathic muscular atrophy. A good deal of confusion appears to exist in the description of the different forms of idiopathic muscular atrophy.

I propose to consider them under four headings:—

1. Pseudo-hypertrophic muscular paralysis (Duchenne's type).
2. Juvenile muscular atrophy (Erb's type).
3. The facio-scapulo-humeral type (Landouzy Déjérine type).
4. Mixed and intermediate forms of the above.

Erb has carefully examined a large number of clinical records of these forms, and has come to the conclusion that they are all varieties of the same disease. One very important point to remember is that hypertrophied muscle may be found in certain parts of the body in all these types.

As to the nature of these curious forms of muscular atrophy, I cannot do better than quote Gowers. "All the diseases of this class seem to depend on a defective tendency in the development of the germinal tissue which form muscles; they are essentially congenital diseases."

Pseudo-hypertrophic muscular paralysis is a disease characterised by enlargement of the muscles with marked loss of power. The hypertrophied muscles subsequently atrophy, and in some cases atrophy occurs in muscles which have never passed through a stage of enlargement. The muscles are usually hard, and feel quite different to the soft, flabby atrophied muscles which result from a lesion of the anterior cornua or the nerves. The characteristic change in the muscle is a deposit of fat and fibrous tissues between the muscle fibres with subsequent atrophy of the fibres. It affects boys more frequently than girls. Several members of the same family are often affected. It is usually transmitted through the mother. The disease usually manifests itself when the child is about five or six years old, or when it first begins to walk. The gait may be unsteady and waddling in character. The calf muscles may be large and hard. If carefully examined for, in addition to these hypertrophied muscles, others may be found showing marked atrophic changes. The most characteristic features of the disease are the curious waddling gait, the feet being wide apart, and the body swaying from side to side, the tendency to walk on the toes, the marked lordosis, the peculiar method of rising from the prone to the erect position, and the association of enlargement of the infraspinatus with atrophy of the lower part of the latissimus dorsi and the pectoralis major.

There is no evidence of the case under consideration being one of pseudohypertrophic muscular paralysis. There is no history of any of the muscles ever having been hypertrophied, and there is no evidence of any of the muscles being hypertrophied or unusually hard at the present time.

The child has not the gait which is characteristic, nor does she, if laid down, rise from the floor in the manner which is more or less typical of pseudohypertrophic muscular paralysis. One of the most important diagnostic signs of pseudohypertrophic muscular paralysis is enlargement of the infraspinatus combined with wasting of the lower part of the latissimus dorsi and pectoralis major. There is certainly no such hypertrophy or atrophy in this case.

In the juvenile or Erb's type of idiopathic muscular atrophy, wasting and weakness usually come on simultaneously in the upper arm and shoulder muscles. The biceps, triceps, and supinator longus suffer. The lower part of the latissimus and pectoralis major may be also wasted. The forearm muscles usually escape and in the majority of the cases the thenar, hypothenar, and interossei muscles are unaffected.

In the Landouzy Déjérine type the facial muscles are involved. The zygomatic muscles waste and there is a loss of the naso-labial furrow. The orbicularis oris is affected and as a result the lips are continually separated. The expression is very dull and the face has been called by Landouzy and Déjérine the "myopathic face."

A further effect of the wasting of these facial muscles is a curious alteration in the smile, the angles of the mouth being drawn upwards instead of upwards and outwards. The patients cannot whistle and cannot perfectly articulate labials. In addition to the humeral and scapular muscles being affected, the abdominal and spinal muscles, the flexors of the hip and the extensors of the knees may become involved. Fibrillation is nearly always absent The electric irritability is usually less to both currents. There is no loss of sensation, and the sphincters are unaffected. As the atrophy progresses, deformities result. The course and duration vary exceedingly. Patients may live for many years; the duration may be said to vary from ten to fifty years. You will see that the case I am discussing does not fit in with any of these types. There is no change whatever in the facial muscles, so that she is not suffering from the Landouzy Déjérine type. The upper arms are not affected, but the thenar and hypothenar muscles are; there is no hypertrophied muscle; there are very marked alterations in the electrical reactions, some of the muscles not contracting to either Faradic or galvanic stimuli. I consider these data sufficient to say she is not an example of Erb's juvenile type of muscular atrophy or of the Landouzy Déjérine form.

It is evident from what I have already said that this case of muscular atrophy I have presented to you, does not fit in with any of the types I have discussed with you so far. There, however, remains a rare form of muscular atrophy which was first of all described by Charcot and Marie in 1886, and in the same year by Dr. Howard Tooth in a thesis entitled "The peroneal type of progressive muscular atrophy." It is usually spoken of as Tooth's peroneal type of muscular atrophy. Gowers describes it as "The peroneal type of family amyotrophy" (neuritic muscular atrophy). I consider the little girl I have shown you to-day to be suffering from this form of muscular atrophy.

In some respects this disease resembles the idiopathic muscular atrophies I have just discussed with you, and is therefore as a rule described with them. It resembles the primary myopathies in several points, the age at which the disease commences, the gradual onset, the slowly progressive character of the malady, and the occurrence of the disease in other members of the same family. It differs, however, markedly in the distribution of the atrophy, and the very definite relation the onset often has to some acute disease such as measles, and, in the case before you, whooping cough.

Males suffer from this form of atrophy about twice as frequently as females. It very rarely commences after twenty, but is usually first noticed in early childhood. It is sometimes hereditary. The wasting first appears in the extensor longus hallucis, extensor communis digitorum or the peronei muscles, and very probably, according to Gowers, it starts first of all in the small muscles of the foot, for a wasting of such small muscles may very easily escape observation. Later on the calf muscles

suffer, and still later the vastus internus. Talipes often results on account of the unequal manner in which the muscles of the legs are affected. Some years after the legs have been implicated the hands and forearms are involved, the thenar, hypothenar, and interosseal muscles being first of all attacked. The supinator longus usually remains normal and so also do the muscles of the shoulder, back and neck. The atrophy is usually, but not always, symmetrical. In advanced cases a claw-like deformity of the fingers may result from the atrophy of the intrinsic muscles of the hands. When this deformity is associated in early life with the wasting of the muscles of the feet and of the peronei, etc., it is almost diagnostic of this peculiar type of muscular atrophy. Occasionally slight fibrillation of the affected muscle is observed. Another very important change is the diminution of the electrical irritability, a point which is of great importance in distinguishing cases of this nature from those of idiopathic muscular atrophy. Faradic irritability early becomes lost and there may be well marked reaction of degeneration. Cutaneous sensibility is usually preserved, but it may be lost or impaired. Pains, and spasmodic contractions of muscles are noticed in some cases. The knee-jerks may be lost. The cutaneous reflexes vary and are often not lost.

You will see that in most respects the case under consideration fits in with this type of muscular atrophy. First of all there is the age of onset; loss of power in the legs was first noticed when she was four years old. It followed an attack of whooping cough. The family history is of importance, for one of the uncles appears to be suffering from a disease of a similar nature, which commenced when he was three years old, and has been gradually progressing ever since. The distribution of the atrophy, and the mode of onset and progression are quite characteristic, for it first of all commenced in the feet and legs, and three years afterwards attacked the intrinsic muscles of the hands. The muscles of the face are not affected, nor are the shoulder, neck or back muscles. The marked diminution of electrical irritability is another important point of similarity, and so also are the attacks of pain in the feet, from which she occasionally suffers, these last two conditions being important diagnostic points of distinction from true idiopathic muscular atrophy.

Then as to the nature of this form of muscular atrophy. I have already alluded to its similarity to the idiopathic muscular atrophies in its slow and progressive course, the age at which it begins, and the affection of other members of the same family, and also to its dissimilarity, in that it is so prone to follow an acute specific disease. This last mentioned important factor in its causation, the alteration in the electrical reactions, and the occasional presence of anæsthesia, are all features which point to marked changes in the nerves as a cause of the disease. There are very few cases in which a thorough post-mortem investigation has been made.

One observer has examined a case and found inflammatory changes in the nerves, the spinal cord being quite free. Tooth advocated a degenerative form of neuritis as the true pathology, and pointed out that such a view would help to explain the occurrence of fibrillation, which is of extremely rare occurrence in any of the idiopathic muscular atrophies. It is, of course, possible that there is a liability to early slow degeneration in the nerves as well as in the muscles. It would appear that in some cases the muscles atrophy because of degeneration of the nerves alone, whereas in others the muscles have a congenital tendency to atrophy as well as the nerves to become degenerated. If there is such a congenital tendency to degeneration it is easy to understand how a disease like measles or whooping cough may act as an excitant and start the process. The slow nature of the process and the liability of other members of the family to be affected serves to distinguish it from cases of pure neuritis.

The prognosis is by no means good. The tendency of the disease is to gradually but surely progress. I am afraid the future of the little patient is foreshadowed by the present condition of her uncle, who now is 39 years of age, and has the greatest difficulty in getting about, having completely lost the use of his hands and feet.

Patients rarely die of the disease itself, but usually succumb to some intercurrent affection such as pneumonia, tuberculosis, etc. Very little can be done in the way of treatment. No good can be hoped for from electrical treatment or massage. The general health must be attended to, over-exertion avoided and strychnine administered internally.

A Nursing Guide.

"The original object in view in the preparation of this work was simply to provide a handbook of the past and present Nurses' League of Guy's Hospital, and a Register of the Nurses trained at this institution. In the course of its preparation the desirability was recognised of including a section which would be of general service to the community. This has been done. . . ." Such is the modest introduction which greets the reader of the Guy's Hospital Nursing Guide. Personally, we do not feel ourselves competent to speak with the voice of the community, nor do we feel inclined to define a general service. We shall therefore content ourselves with discussing its value in the tiny little world of Guy's, with an honest endeavour to speak the whole truth and nothing but the truth.

How many nurses are there who have embarked upon their careers with an Adelphian, Hall Caineish ideal? How many have received subconscious promptings to a life of altruism? How many have simply been attracted by a desire for knowledge and a becoming uniform? The promptings of a boy of ten lead commonly to the profession of engine driving, and it is only maturer consideration and an appreciation of the necessity of earning an income commensurate with his ideas of comfort that lead to the choice of a more sober and lucrative employment. So we think it is with the other sex. In the great majority of cases the nursing profession is adopted as an honourable means, noble an you will, of obtaining an independent livelihood. It is possibly true that nurses, like poets, are born and not made, yet a very colourable imitation of either article can be produced by suitable training.

Realising that some sort of model must be adopted to the level of which the pupil is to be steadily raised—a nursing "bogie" so to speak—the guide very properly opens with an essay on the ideal nurse. It is a good essay, with much home truth forcibly expressed. Tact, that most precious of attainments, receives its due prominence and is dealt with in a manner which suggests a mastery of the subject. While it is the duty of the nurse to know, it is equally imperative that she should inspire a sense of her knowledge without an appeal to words. Also it is alike necessary not only for the patients but for her own peace of mind that she should appreciate the limitations of her knowledge. She may often be tempted to an expression of opinion on a matter quite outside her experience, and she must remember that the public is inclined to attach a gravity to her words which is quite unjustified. It is a wholesome section, this part of the Guide, and is applicable to others than nurses.

Next in sequence of pages comes "Useful nursing information," a section which certainly justifies its title, though we must confess to a certain amount of sorrow at the sight of that poor old hard-worked obstetrical table, printed, no doubt as a novelty, sideways. Of the useful recipes we cannot presume to speak beyond remarking that the quaint phraseology of Mrs. Beeton has been preserved with all its pristine charm. With a collection of legal tit-bits and particulars of the regulations in force in the School of Nursing at this hospital and in the institute the general service to the community ends. The second half is devoted to the Nurses' League. In addition to some pages of padding, mostly cut without acknowledgment from the Gazette, there is a highly useful register of trained nurses and also a list of associates of the League; these, with postal and cab information complete the contents, and there remain but the covers. Financial considerations, doubtless, are responsible for the inclusion of advertisements in the book; and financial considerations must always be allowed their due weight. We cannot help thinking, however, that half a dozen pages of uniforms, boots and folding-beds would have been less distasteful had they been flanked by paper covers. The dignity of binding in "boards" is sadly marred by the inclusion of advertisement pages, and always suggests the very cheap novel.

On the whole, the book should be useful, not only to the Nursing Staff but to old Guy's men in practice, for the latter are able by reference to the register to exercise a selective capacity in engaging a nurse, which must not be taken to suggest that all Guy's Nurses are not admirable.

In a later edition, doubtless, the motto of Guy's will not be put so very close to the price of the book. "Dare quam accipere" one shilling and sixpence is not unfunny.

S.

Pass List.

Royal College of Physicians of London, July, 1902.

ADMITTED TO THE MEMBERSHIP.

George Norman Meachen, M.B., B.S., L.R.C.P. Lond., M.R.C.P. Edin.

Royal College of Physicians and Royal College of Surgeons in Ireland, July, 1902.

EXAMINATION FOR THE DIPLOMA OF PUBLIC HEALTH.

C. D. H. Rygate.

Passim.

Elsewhere will be found the text of some proposed alterations in the rules of the Clubs' Union. It is now common property that the finances of this institution are in a very perilous condition, and that some radical measures are necessary if a state of absolute bankruptcy is to be avoided. It will be remembered that under the old régime five annual payments of two guineas, or a composition fee of eight, gave the privileges of life membership, and entitled the subscriber to five years of the Gazette and the Reports. While our natural modesty restrains us from commenting on the fate of the Gazette, we can state confidently that in the case of the Reports, eight subscribers out of ten saw little more than the covers of this excellent publication. The necessity for its existence died out with the rapid increase in medical publications, and to-day there is nothing published in the Reports which could not be expressed as well, or even better, in the Guy's Hospital Gazette. We therefore welcome the suggested alteration in Rule 1, which would delete the word "Reports" from the list of constituent institutions.

The nett result of this amendment will be an additional hundred pounds yearly in the coffers of the Union. It may cost the ambitious man some little chagrin that his audience should be thus summarily reduced, but the advantage to the Clubs' Union and Guy's men, as a whole, will more than compensate for this moral and intellectual damage. The second amendment abolishes the composition fee, and defines the time at which the subscriber shall become a life member as "the date when he obtains a registrable qualification to practice medicine" or dentistry, as the case may be. Under the existing regulations, this implies a five years' subscription *at least*, and in the case of the more long-winded or less successful venturer, an even larger subscription. When it is considered that the advantages of the Clubs' Union are enjoyed almost solely by those members who have necessarily to be in attendance at the hospital, it seems to us to be logically right that such men should pay a subscription proportionate to the benefits that they derive from the Clubs. The necessity for an increased income is imperative; therefore must those who call the tune pay the piper.

The only other point that calls for comment is the clause which gives the Council of the Union power to fix the amount of the annual subscription. As enunciated, the rule does not express whether the Council shall fix the subscription for each year or shall adjudicate now and for all the amount to be paid in future. That is to say, we have no guarantee that the subscription fixed for one year will be the same in the ensuing years, and an estimate of the probable cost of life membership becomes accordingly exceedingly vague. It is a curious fact that there is no appeal from the decisions of the Council; there is no general meeting of members to which the Council is answerable, nor has the Union, as such, the slightest check upon its actions. The method by which the Council is elected, moreover, is so exceedingly complex, that any attempt at co-operative action in pursuance of a definite policy is rendered exceedingly difficult. Small wonder, then, that the "man in the street" feels that the Council does not represent him, is not in sympathy with his aspirations, and is utterly and entirely removed from him.

We do not suggest that the Council of the Clubs' Union is not a fitting instrument for the assessment of the yearly subscription. On the contrary, it has always proved to be the case that a carefully selected committee, empowered with full authority to act, is more capable of dealing with matters requiring an investigation of details than a large and heterogeneous general meeting. What we do suggest, however, and the alterations in the rules give us a convenient opportunity of expressing our views, is that the method of electing the Council is wrong. The Staff moiety is elected at a School meeting; the student half should be similarly elected at a general meeting of all members of the Clubs' Union. And to ensure that the election should be whole-hearted, the quorum necessary for the transaction of business should be large. Only

give due prominence to the importance of the functions performed by the Council, and the elective general meeting would not suffer in numbers.

WHEN the Treasurer spoke, at the Biennial Dinner, of the Fives Court, with its historic gaps and cracks, we little thought that he was sounding the death knell of its imperfections. But now the court has passed through the hands of the repairers, and offers fresh attractions in its smooth walls, its level floor, and its loud-sounding baulk line. True, when all was done a new door yawned in one side wall, that the bathers might reach the swimming bath in ease and comfort, and not risk their limbs by the grinding jaws of the mechanical stoker. In gratitude at least, omitting all references to courtesy and good taste, intending bathers should ascertain that a rally is not in progress before opening the door leading in to the court. Nothing is more irritating than to have an exciting finish spoilt by the intrusion of a towelled head in the line of sight of the striker and the ball.

A NEW method of aërating the lungs has been discovered. The roof of the present Wills' library, lately the nursery, is surrounded by a high net wall, and offers exceptional advantages to the stump cricketer. So far the present firm of Clinicals has defeated all comers, mainly owing, as they admit, to the strength of their ground staff. North versus South, England versus Australia, and other important fixtures have already been decided, and the game bids fair to supplant in interest the tugs-of-war which were so popular last year. Naturally, cooped up in an unhealthy atmosphere, the men must take every opportunity of getting exercise in some shape and form, and the present craze seems to be, viewed in this light, admirable. The inhabitants of the nursing home, however, who are forced to get their sleep in the afternoons, find the vocal efforts of the players extremely distressful, and we trust that the men will show some consideration for the feelings of the night nurses, whose slumbers have been sadly disturbed by the shouts and laughter of the players.

WE have been requested by the Secretary of the Belgian Surgical Society to state that the Annual Congress will take place at Brussels on the 8th, 9th, 10th and 11th of September, 1902. The Society has invited the most eminent surgeons of the world to attend the Congress, and hopes to establish an International Surgical Society. Discussion will be invited on the treatment of appendicitis, the treatment of fractures, and the best methods of attaining asepsis in operative surgery.

THE London gutter press usually offers, as a piquant morsel for its readers, a Hospital Scandal at least once a week. Lately, however, the journalistic imagination has taken a fresh trend, and the general practitioner is receiving its unwelcome attention. A child, who had been terribly scalded, was admitted into Guy's at midnight and died a few hours later. It transpired at the inquest that he had been seen by a medical practitioner shortly after the accident at mid-day, who, in response to the query whether the child should not be sent up to the hospital, remarked, not unnaturally, that if the parents took him up to the hospital in his collapsed condition the journey would be fatal. The father, fearing, after the child's death, that he might have accelerated the end by bringing him to the hospital, asked the house-surgeon in court whether the child could have lived under any circumstances, "for," he said, "the doctor said if I took him up to the hospital it would kill him." The answer was in the negative, and the jury were asked by the coroner to state that in their opinion the bringing of the child up to Guy's had not caused the death. In the report of the inquest, one leader of public opinion came out with a leaded title—"If you take him to the hospital *they* will kill him." Only the alteration of one word, but it served its purpose.

A NEW antiseptic, termed creasol, has lately appeared in the wards and operating theatres. The advantages claimed for this drug are primarily, cheapness, and secondarily, greater germicidal powers than the more familiar lysol. Experience, however, has shown that it possesses remarkable properties of its own. It has

apparently a specific irritative action on the skin, which is appreciated a few moments after its application. So well marked is this that one surgeon had to protect his arms with sterilized pads from contact with the wet creasol towels. The dressers, too, have complained of painful dermatitis of the forearm through contact with the fluid, and compresses of creasol have had in some cases a disastrous result. Much is sacrificed in modern surgery on the altar of asepsis, but creasol promises to be the proverbial straw.

In the *Times* of the 6th inst. appears a report of the proceedings of the Committee of the Hospital Sunday Fund. After correcting the Lord Mayor, who had remarked that Guy's had still beds unopened, and we believe old Mary Ward to be still tenantless, Sir H. C. Burdett referred to the money which was being wasted on nurses. He proceeded to remark that recently a perfect palace had been opened for the accommodation of nurses, and now that it was opened, the nurses confessed that their old quarters were considerably more comfortable. His remarks could only refer to our Henriette Raphael Nurses' Home. If he intended by the use of the word "palace," to imply a condition as nearly approaching perfection as is possible at present, we must agree that the Nurses' Home is a palace; but when he enunciated his astounding statement that the nurses were dissatisfied with their new quarters and sighed for the dirty old cubicles in the attics, he must have allowed his tongue to outrun his reason.

The interest which has recently been aroused concerning the history of perityphlitis led us to publish in our last number the paper which Addison originally wrote on the subject in his Practice of Medicine. The date which appears on the copy in the Hospital Library is 1839, but an earlier edition by three years proves to exist. Although in one of the cases quoted an abscess was opened by the surgeon, this can hardly be spoken of as an operation for appendicitis, and it appears quite clear that the disease was recognised by the physicians long before surgical assistance was called in.

Dr. Habershon's work is not alone amongst the medical works of nearly fifty years ago in its discussion of the subject; articles of some length are to be found in the first edition of Sir Samuel Wilks' Pathology, which is a reprint of his lectures in 1857-58, in Reynold's System of Medicine published in 1870, in Bristowe's Practice of Medicine, and in others of the same time.

Attention is drawn to the Final Fellowship classes which are to be held for the forthcoming examination. Further particulars will be advertised in the next issue.

The next House Dinner will be held on Wednesday, October 1st, at 7 o'clock. Dr. Goodhart will be in the chair, and we are informed that the Lord Mayor will honour us by his presence.

There is no foundation for the rumour that the temporary nurses' home which was lately vacated is to be blown up or pulled down. It is merely being worried a little at present by the Morlocks of Guy's now that the Eloi have departed, in order to fit it for the requirements of our librarian. When the old library and its custodian are transferred to the new buildings, it should be better for both, albeit a shock to the affectionate memories of old Guy's men. Then at last we may have that Drunk or Dying ward which has been in the air so long, and prematurely grey heads may grow scarce once more.

A committee has been formed with the object of obtaining subscriptions and devoting them to some form of memorial to the late Dr. Washbourn. The list will be opened in October, and subscriptions will be limited to a maximum of two guineas.

The dangers which beset those who struggle on through life at Guy's are not all bacillus born. Happy are they who apply for insurance policies against accidents on their entry at Guy's, and do not wait until the bitter experience of sprained ankles and broken knees teaches them what are the treacherous spots around us to be

avoided. There are many such—the step in the dark towards the smoking-room, the neighbourhood of the fireplace in the surgery, the tortuous descent to the baths, etc., etc.; but of all the most dangerous and most treacherous, two stand pre-eminent—the colonnade steps and the gas brackets of the underground passage to the College. The colonnade steps, the pleasant rendezvous of after (and before) lunch loiterers, have been worn by countless footsteps until their surfaces are no longer horizontal, but sloping, with a dangerous inclination to the ground below; to those who know them, the danger is discounted, but their effect upon the unfortunate patients who stumble, medicine-laden, up their ledges homeward bound, is shown by the frequent presence of broken bottles at their base.

As regards the gas brackets in the underground passage, the effects of the accident, which will one day lead to their abolition, are too horrible for contemplation. Sometimes the gas is lit, and sometimes not; there is always a goodly time in the twenty-four hours when it is not, and the burners cannot be seen in the gloom. They are just on the level with a man's eyes, and men walking confidently in the gloom bring a considerable momentum to bear. Need we say more?

THE new telephone with its mystic numbers has not proved a complete success as yet, and our hopes which were temporarily raised at the sight of its imposing complexity are once more dashed to the ground. An attempt to call up Mary Ward in haste results in an answer from the Board of Works or some other equally uninteresting depot. On an average, the telephonic system at Guy's is imperfect six days in the week and a perfect wreck on the seventh. Much irritation can be excited by the total failure of an attempt to get through to a ward or to the Surgery; friendships can be broken by an imperfect connection which allows the voice to be transmitted in one direction only. Perhaps we exaggerate slightly, but the consequences when the total wreck occurs not only cause much discomfort and delay to patients and endanger the mental equilibrium of taking-in officials and of despairing porters, but are occasionally still more serious. If So-and-so is wanted at once in a ward, and the message does not get through, So-and-so does not get there, and the blame may fall unjustly.

AGAIN, it is a little hard that a resident who is confined to the hospital for a fortnight on end should not be able to sit in the park to enjoy fresh air without qualms of conscience that he may be wanted by the porter, who must not leave his post to fetch him. Surely, what we need is a couple of messenger boys—one to be kept at the College, one in the Surgery. Even one would be a vast assistance, as the telephone between the Surgery and the College is the one which least frequently breaks down; he might be under the orders of the College porter. A boy eats more than a telephone, but can be relied upon not to break down suddenly. There must be a good deal of work in various ways in which he could be made useful apart from his message-carrying capacity. His cost would be trivial in comparison with the value of his work.

A SHORT time back we commented upon the condition of the Assistant House Physician's room and upon the ill effects of its badly ventilated gloom on the holder of the appointment and his patients. We learn that an old Guy's man who was showing friends over Guy's, failed to convince them that the room was in use for the examination of patients. One cannot be surprised that people who have seen the greater part of Guy's should refuse to believe that that poor den was anything but a relic of the past.

From the Gazette's Special Pathologist.

C., SAXMUNDHAM, SUFFOLK.—The vomit (or stomach washings) had a strongly alkaline reaction. There was only a small amount of deposit, which consisted almost entirely of squamous cells from the pharynx. A red blood disc was noted here and there, but there was no excess of leucocytes or gastric epithelium. There was no food matter present, and the sarcinæ ventriculi was not seen. NOTE.—No information has been received as to the nature of the examination required.

PATHOLOGIST.

Guy's Hospital Clubs' Union.

NOTICE OF ALTERATION OF RULES.

Notice is hereby given that the following changes in the rules of the Clubs' Union have been passed by the Council and will be confirmed at the next meeting of the Council, to be held on the 15th September, 1902.

Rule 1.—The word "Reports" to be struck out.

Rule 16 to be replaced by the following:—

Every Student of the Hospital shall be entitled to become a member of the Union on payment of the annual subscription and shall (subject to Rule 21) remain a member so long as he shall continue to pay regularly the annual subscription. The amount of the annual subscription shall be fixed by the Council of the Union. Any change in the amount of this subscription shall affect every subscribing member of the Union and shall be regarded as an alteration in the Rules (see Rule 23).

Every Medical Student who joins the Union on entrance to the Hospital and continues to be a subscribing member until the date when he obtains a registrable qualification to practice medicine, shall become a life member of the Union without further payment.

Every Dental Student who joins the Union on entrance to the Hospital and continues to be a subscribing member until the date when he obtains a registrable qualification to practice dentistry, shall become a life member of the Union without further payment, provided that he is not studying for a medical qualification.

A member who by reason of his absence from the Hospital for a period exceeding twelve months is permitted by the Council to temporarily suspend payment of his subscription, shall not thereby forfeit his right to life membership.

Any qualified Medical or Dental practitioner a former Student of Guy's Hospital previous to the formation of the Clubs' Union (1891) shall be entitled to become a life member of the Union on payment of five annual subscriptions of five shillings or a composition fee of one guinea.

(Signed) T. J. STEWARD,
Hon. Sec., Clubs' Union.

Papers by Guy's Men.

On the Acetone Series of Products in Connection with Diabetic Coma. By F. W. Pavy, M.D. Lond., LL.D. Glasg., F.R.S.—*The Lancet*, 9th August.

The Diagnosis and Treatment of Malignant Stricture of the Œsophagus. By Charters J. Symonds, M.S. Lond., F.R.C.S.—*Ibid.*

In the Wards of the West London Hospital with Dr. Donald Hood.—*The Clinical Journal*, 6th August.

A Sussex Elysium.

"Solitude sometimes is best society,
And short retirement urges sweet return."
——— *Paradise Lost.*

Ye jaded creatures which seek relaxation from toil, and ye that would fly the red pleasures of town for bucolic seclusion, attend while I sound the praises of Frant, in the county of Sussex!

Thou sweetest of sylvan retreats, thy fairness and beauty will ever live green in my memory.

I have lain under thy trees and cooled my heated brow with thy zephyrs. Thy fresh bosom hath taught me the poetry of rustication and stirred within me the few finer feelings that yet remain.

Within thy bounds would I die and be buried, that I might at length form part of thy dear soil.

* * * * *

Frant is on the main line of the South Eastern Railway, about two and a half miles south of Tunbridge Wells.

When you leave the station, you pass the "Brecknock Arms"—great assumption!—and steer to the right. This is the road to Frant.

About midway between the station and village, and lying back from the roadway, is the Manor House, or Manor House Farm.

The old fashioned gables and chimney stacks lend a picturesque appearance to the house; but the charming view from the garden transcends everything.

In the foreground are an orchard and green meadows sloping to a wood, and in the distance a glorious expanse of hilly woodland completes the panorama.

I have sat in the garden and surveyed the view while my soul has skipped about in front of me on the grass in rapturous appreciation!

Like most old buildings, Manor House can boast its ghost. A shadowy gentleman is said to haunt the kitchen garden, which is enclosed by some old monastic walls.

If instead of gliding among the vegetables he would cross our path (yours and mine, dear reader), after a heavy night at "Jimmy's," he might be of some use to society. But this is digressive.

Quitting the Manor House, and continuing your course along the road, the village is reached.

Observe the church, the Abergavenny Arms, the quaint little post office, the pump, and the pretty Green.

The small tree on the Green was planted by the Marquis of Camden, to commemorate his coming of age. I mention this, as some of you may like to lick its bark, knowing the tree's history. Personally, I should rather be excused, as I am no great admirer of the aristocracy, and do not consider the tree morally, spiritually or intellectually, the better for being planted by a nobleman. Of course, you will call me a scurvy, unwashed socialist; but great reformers are used to this dignity of address, and pursue their noble work of amendment in silent contempt.

Crossing the Green, and passing some villas and cottages on the right, you will notice a stile.

This is an entrance to Eridge Park, the property of the Marquis of Abergavenny, who, with Lord Camden, is the owner of most of the dirt in the district. In Eridge Park you may roam without let or hindrance and exclaim with the Gentleman of Verona,

"Here can I sit alone, unseen of any,"

for the absence of all things human must cheer the heart of the most exacting misanthrope. You are not pestered by notices requesting you to abstain from spitting on the grass and chasing the deer. The romance of natural beauty is quite shorn by tabulated penalties and lists of convictions at every point of view. To be made aware, after gazing upon a Turnerian sunset, that some miserable wretch has violated a local bye-law is a headlong descent from the high to the low, and annoying in the extreme. Despite my socialistic tendencies, I cannot but admire Lord Abergavenny's spirit of indulgence, and for this reason would leave his head to the last.

In an obscure corner of the park are some caves and mineral springs. Observe the cavity of the caves, and then direct your steps to the springs. These are said to possess excellent medicinal qualities, and are much valued on this account, being similar to those at Tunbridge Wells. The waters in the district were discovered, according to the guide books, by a Lord North, in 1606, whose town dissipations had shattered his constitution. A complete recovery was effected; but whether he returned to his wild oats is not recorded.

Returning to the roadway, and continuing your walk for a short distance, the Hastings Road is reached. I mention the Hastings Road as it recalls tender memories; nay, nothing more in troth, facetious reader! For the world's spotty influences are with me still, and to my suppliant cry Hymen turneth a deaf ear.

But again I digress.

Approached by a long, narrow lane near the Hastings Road, and leading from the main highway, is a charming house known as Lightlands. How long it has been built I cannot say, but local tradition asserts that it stands on the site of a hunting-box used by King John. No, no, I do not guarantee the accuracy of the assertion, and for my part, am quite indifferent whether it be true or false.

At best, John was but a big, blasting bully—if he deserve such laboured alliteration—and his disgraceful treatment of poor little Arthur would have shamed Herod.

However, I can imagine John on a hunter harrying the big game, while his retainers meekly followed, in the vain hope that he might break his neck. But *de mortuis nil nisi bonum* is right, and I accept the reproof.

Within a short distance of Lightlands is Pocock's Gate. This is another picturesque farm, and to those who are fond of the antique in architecture it will possess attractions, as it is built of wood, and for oddity of design and lack of the conventional is unique. Forming part of the land belonging to the farm is a beautiful meadow of some acres in extent, and which being raised above its immediate surroundings, must have been specially engineered by Nature for the erection of a house. I have surveyed this spot with much the same longing as that with which Moses gazed upon the Promised Land from the top of Pisgah; but alas! like he, I am doomed to disappointment, for the ground is manorial, and land syndicates are unknown; and when I visit the fair mead it is to shed a tear on the grass and deplore the heartlessness of its owner in denying me my desires' consummation.

The places of interest in the immediate vicinity are many. Foremost, unquestionably, comes Tunbridge Wells, whose Common, high rocks and pantiles will never languish for plaudits of a guide writer.

Although the glory of the pantiles has somewhat waned, there is still an eighteenth century air about it, and to the true sentimentalist—who, like the screech-owl, is fast approaching extinction—much pleasure can be derived from treading the classic ground; for here it was the wit and wisdom of the above period congregated to drink the waters, they who live in our memories as the authors of Clarissa, Tom Jones, Rasselas, and a hundred other mighty conceptions.

Two or three miles to the east of Frant is Bayham Abbey, the seat of Lord Camden. The park, unlike Eridge, is not open to the brutal public, and if you wish to walk through it you must be prepared to incur the keeper's wrath.

Although such a course cannot be recommended, I have never regarded this particular form of trespass as one for which you need pray forgiveness; and to me a ramble through a private enclosure is the sweeter for being forbidden.

The house is quite modern, and not comparable with Eridge Castle, Lord Abergavenny's place, but the Abbey ruins are interesting, and the lake is a dream.

To the south is Best Beech Hill, from which a glimpse of the sea can be obtained, and Wadhurst, an old-world Sussex hamlet.

To the west Crowborough and Broadwater Forest may be visited. There is no water at the latter place, and why this equivocal description should be applied does not appear. Somebody suggested, when I was there, that the local topographer was suffering from hydrocephalus when he christened the place; but I dismissed the proposition as altogether too apocryphal.

In conclusion, I would advise you to spend a week-end at Frant, that you may judge for yourselves whether it be worthy my encomiums.

This unyielding pen cannot describe the thousand shades of the woodland, the chorus of the birds, or the weird bark of the foxes at night; yet twelve leagues from St. Thomas's Street they may be known and understood, and for the journey you may receive impressions of Flora and Fauna which should remain indelible to the last.

R. C. A.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Hereafter.

Sir,—I have followed the interesting correspondence evoked by "Spero's" article in your two last issues, from which it appears that "R.H.F." and "P.G." look at the subject from very opposite standpoints.

It is good, no doubt, to "have a giant's strength, but tyrannous to use it like a giant." A "smart" diagnosis, especially if correct, is a grand thing for one's reputation; at the same time, to noise it abroad at the expense of the "other man" will inflict a more grievous and irreparable injury upon the latter than a downright libel. I do not wish for one moment even to appear to suggest that "Spero" would deliberately employ such a method of demonstrating the doctrine of the survival of the fittest. A small pebble cast from a sling may sometimes be more deadly than a sword-thrust.

There are one or two points, however, in "P.G.'s" letter to which some exception may, perhaps, be taken. It is stated therein that the greatest incentive to hard work is the "pleasure of excelling." Surely, this is a very low estimate to take, and one which does not appear to find a place even among the humbler creation. Is it to be supposed that the bee toils all day long among the melliferous blooms and returns home laden with the precious spoil simply with a view to "excelling" other members of the apian community? Shades of Maeterlinck! To come nearer home, does the enthusiastic student in the laboratory, engaged in some special research, perhaps within measurable distance of some important discovery, work at that bench or pore over this microscope, merely for the purpose of "excelling" his colleague? Has he no thought for the future, no inward sense of satisfaction for good work done for the work's sake, no ardent desire to see a solid foundation laid upon which others after him will build their superstructures? I am sure he has. We have only to look at the records of the Guy's workers, past and present, to feel at once that they were actuated by such motives, not by the pleasure of doing alone and still less by the desire to excel.

I am far from disparaging healthy competition, which in its proper place is good, but what I desire to maintain is that the best work and the most lasting is done by those who labour for the work's sake, and who ever bear in mind a future, if not a present and more tangible reward.

There is a very subtle moral pathology conveyed in the closing sentence of "P. G.'s" letter. That the public "have a right to ask a man's best" no one will deny, and the more a man realises the value of scientific training and methods the better will his best be.

"R. H. F.'s" advice is, after all, only an application of the golden rule which again is, in reality, nothing more than an elevated expression of common sense. How a "curiously altruistic consideration" should "tend to make a man withhold his best" is a little difficult to see. One would have thought, reasoning upon the same lines as "Spero" and "P. G.", that the more altruistic a man is, the greater need there would be for his best to be given. Moreover, "dishonest craftsmen" are not, as a rule, famed for their altruism,—I am, yours faithfully,

M.

A Curious Case.

A married multipara, under forty years of age, menstruated on 2nd March. On 10th April, thinking she was about six weeks pregnant, she did something with a penholder — the penholder slipped out of her fingers and disappeared. Her usual doctor saw her on 11th April and "found her in bed suffering great pain; she complained of pain in making water and a desire to pass it frequently in small quantities; there was no discolouration of the urine nor any blood-stain on the nightdress which she had been wearing almost entirely since the disappearance of the penholder. On vaginal examination there was a feeling as of a distinct ridge anteriorly and slightly to the left of the middle line, and the anterior pouch in front of the os uteri was apparently almost obliterated by tension of the ridge. There was considerable pain on pressure on the ridge, and on pressure over bladder in front."

She was admitted into Infirmary and examined under an anæsthetic—the interior of bladder and uterus and rectum were explored—nothing was found.

On 2nd May, a projection was felt through abdominal wall in region of right ovary. From the 5th May to the 10th May she apparently menstruated.

On 12th May, laparotomy was performed. A coil of small intestine was prominent containing a pointed substance, the lower end of this was fixed in a matted mass in Douglas' pouch—an endeavour was made, but failed, to remove the substance by way of vagina—the intestine was opened and a porcupine penholder four inches long with a metal tip (the tip being the part felt in the intestine) was removed. The wound in intestine was closed with Lembert suture, the abdominal wound sewn up. No symptoms followed. The rectum was emptied on May 15th by an enema; a dose of castor oil was given on 20th May.

Patient went home at end of second week in June. On 24th June she had hæmorrhage from vagina; this subsided after a few days in bed. She left her bed and was comfortable on 30th June.

On 3rd July she was delivered "of a male fœtus nine inches long and apparently of between fourth and fifth months of gestation."

Nursing News.

Matron's Office.

Again this year the Nursing Staff and others were invited by the Treasurer and Mrs. Cosmo Bonsor to garden parties at Kingswood Warren on the 22nd and 23rd July. The guests, numbering about 120 each day, left London Bridge in a special train at ten minutes to two, Mr. Bonsor travelling down with them. Unfortunately the first day the weather was wet, but in spite of this everyone thoroughly enjoyed themselves. The spacious drawing-room was cleared for dancing, and this was indulged in by some of the guests after light refreshments had been served. Others played ping-pong or listened to the band in the hall, and some braved the elements and went out into the beautiful grounds. On the second day the weather was all that could be desired, and the guests were able to visit the church, farm, kennels or garden; some wandered through the woods and moors in quest of heather and bracken, and others played lawn tennis and croquet, or sat under the trees listening to the band on the lawn. At five o'clock a cold collation was served in a large marquee, after which the visitors were given permission to pick the flowers in the garden. At half-past six the party assembled on the lawn and hearty cheers were given for their kind host and hostess. A start was then made for the station, and London Bridge was reached about half-past seven, everyone having spent a most enjoyable time.

Miss L. V. Haughton, Sister Astley Cooper, has been appointed Lady Superintendent of Sir Patrick Dun's Hospital, Dublin, and has left the Hospital to take a short holiday previous to taking up her new duties. Although much regret is felt by the Nursing Staff at Sister Astley Cooper's departure we are sure everyone will wish her much success and happiness in her new work. Miss Haughton entered the Hospital as a Probationer in December, 1896, and has held the post of Sister since January, 1900.

Miss Alice Park, who completed her training in September, 1901, and has since been Sister at a Surgical Home (29, Wimpole Street), has been appointed Probationary Sister of Queen ward.

Miss Lucie Reed who completed her training in September, 1900, and has since been on the Staff of the Private Nurses' Institution, has been appointed Holiday Sister.

Sister Rennie, Sister of the Isolation wards, has been appointed Sister in charge of the Wardmaids and daily workers.

Nurse Whittingham (Head Nurse in the Theatre) who completed her training in June, left the Hospital on the 26th ult. Nurse Lewin was transferred to the Theatre and Probationer Norman was appointed to succeed her as Head Nurse in the Surgery.

On August 13th, Nurse K. Moore left the Hospital on completion of her three years' training, and Probationer Hooper was appointed to succeed her as Head Nurse in Job Ward.

On August 23rd, Nurse Connolly left the Hospital, on completion of her three years' training, to take up her duties on the Staff of the Private Nurses' Institution; and Probationer A. Rogers was appointed to succeed her as Head Nurse in Queen Ward.

Reviews.

The price of books submitted for review should in every case be stated.

A Text-book of Insanity. By Charles Mercier, M.B., M.R.C.P., etc. (London: Swan, Sonnenschein & Co.) Price, 6s. nett.

The student of psychology is usually struck at the outset of his studies with the peculiarly bewildering phraseology of the subject. Should he succeed at once in mastering the niceties of language which appear to be inevitable in mental physiology, he is generally worried by the elaborate and involved diction with which the author clothes or disguises his thoughts. It is therefore a matter of much moment that the author of the book under review has succeeded in expressing himself simply, intelligibly, and in excellent style. Sentence follows sentence with delightful ease, and the reader is enabled to follow the drift of the writer without any mental gymnastic effort.

The book does not aspire to be more than a sketch of insanity, for the writer appreciates that the average student and practitioner has little time to spare for what is in most cases an outside subject. He has therefore aimed at putting the gist of his subject in a readable and comprehensible form and he has undoubtedly succeeded. There are but a couple of hundred pages of well printed matter, in striking contrast to some of the portentous treatises with which the medical student is afflicted, but in these two hundred pages he has included a great deal of valuable material, and what is still more to the point, he has expressed himself in a form which appeals to the reader. If we might make a suggestion, the book would gain in value by a somewhat fuller chapter on the placing of insane persons under control.

Thomas Henry Huxley. By Edward Clodd. (William Blackwood & Sons).

Mr. Clodd is well known to us by his numerous popular expositions of scientific subjects, and in his latest publication he well sustains his past reputation. To write a brief biography is in many respects a more

difficult task than to prepare one of full detail, for the *man* can be adequately pourtrayed only by the narration of numerous little episodes and incidents in his everyday life, and to those who find a never-flagging fascination in the study of human nature, a biography is of interest just so long as the man himself is seen. An account of his writings and of his discoveries are in more proper place in the history of the subject with which he has to do than in his biography. This difficulty Mr. Clodd evidently felt, and within the limits of two hundred pages he has attempted its solution by devoting the first quarter of the book to the man, the remainder to chapters on his work as discoverer, interpreter, controversialist and constructor. Though this way out of the difficulty is of all the least unsatisfactory, it gives a disjointed character to the book, which really becomes a series of five essays on Huxley from five different standpoints. And this the author realised, for on the title-page he puts merely "Thomas Henry Huxley," unprefixed by "Life of" or "Biography of," and if we regard the book from this point of view, the result is wholly successful. His chapters are full of judiciously selected extracts from Huxley's writings and letters, whereby more life is infused into the pages than if a sparing choice had been made. The account of Huxley's connection with Darwin's "Origin of Species" is well told —briefly, but sincerely—and, indeed, all the more important events in the great naturalist's life find a sympathetic pen in these pages. The life of this strenuous and deep-thinking man is presented to us as a sequence of admirable pictures, painted with boldness and decision, yet never heavily, nor in ill-proportion.

Elementary Text-book of Zoology. By Arthur T. Masterman, M.A., D.Sc., F.R.S.E., 2nd edition. Price, 12s. nett.

The proof that this book supplies a real want is afforded by the fact that a second edition has been called for within twelve months of the first, and to one conversant with the needs of the zoology student this rapid sale is not wholly surprising after a perusal of the work. Its general arrangement shows that it is obviously written by one who has experience in the preparation of men for examination, and, by a judicious emphasis of salient points, a profusion of illustrations for the most part original, a conciseness of style and clearness of type, a really excellent result has been obtained.

The book is admittedly written with a view to use in the Scottish Universities, and as their course of Zoology covers a more extensive range than is needed by the simpler syllabus of our Conjoint Board, or even of the London University, this text-book is not likely to attain much popularity among medical students in the Metropolis, though we can cordially recommend it to those aspiring to science degrees.

The book is commendably free from mistakes, but on p. 108 for a diagram of a Sycon we are referred to one of an Ascon and *vice versâ*.

Notes on Materia Medica, Pharmacology and Therapeutics, for Dental Students and Practitioners. By Douglass Gabell, L.R.C.P., M.R.C.S., L.D.S., Assistant Dental Surgeon, Royal Dental Hospital, and Harold Austen, M.D., B.S. Lond., L.R.C.P., M.R.C.S., L.D.S., Assistant Dental Surgeon, Royal Dental Hospital, and Lecturer on Materia Medica to the London School of Dental Surgery. (London: Claudius Ash & Sons, Limited, Broad Street, Golden Square, W.) Price, 7s. 6d. nett.

At the onset, we wish to say we are not satisfied with any *Dental* Materia Medica, as we feel the subject can be best dealt with in a more full and comprehensive manner as an addendum to a standard work on Materia Medica.

In proof of our contention we may state, for instance, that perchloride of mercury—its synonyms, dose, solubility, incompatibles, preparations, symptoms of poisoning and treatment—is disposed of in a few lines, whilst its uses in dental surgery as an antiseptic and disinfectant are more fully given. Nitrate of silver, chloride of zinc, arsenious acid, potassium hydrate, carbolic acid, sulphate of copper, and other chemical substances are described in a similarly brief manner; but we think the average student or practitioner requires to have put before him at the same time the preparation of these substances, and their use and action in general medicine. It may be said that a previous knowledge of materia medica is presupposed, or that other works can be consulted, but that does not invalidate our contention.

The book under review deals with the pharmacological classification of drugs—caustics, counter-irritants, astringents, local stimulants, mummifying agents, styptics, hæmostatics, antiseptics, disinfectants, antacids, etc.—and although this classification has some advantages, "it involves a good deal of cross-reference," as the authors say in the preface.

We think the information given accurate and reliable so far as it goes, and many remedies, comparatively recently used, are included, *e.g.*, the coal tar derivatives, hydrochloride of eucaine, formic aldehyde, milk of magnesia, and supra-renal gland.

Some subjects could be given more fully with advantage, such as, for instance, the administration of chloride of calcium as a general hæmostatic—an invaluable drug, the use of which was first advocated, we believe, by Lauder Brunton. Again, various formulæ for mummifying pastes for root canals are known, and some might be given for what they are worth.

A chapter is devoted in the appendix to filling materials. It is impossible to summarise the properties and uses of gold, amalgam, osteo-plastic, and gutta-percha fillings within the short space given (eleven pages), and apart from this objection we think the subject has no place in any work on materia medica, and should be omitted in future editions.

We note the authors say, concerning powdered cuttle fish, "its use is, as a rule, best avoided as likely to abrade the enamel," yet it is put as one of the ingredients in the only prescription given for a tooth powder, excepting one for precipitated carbonate of calcium alone. Inasmuch as powdered cuttle fish consists chemically of carbonate of calcium, and its use other than as an antacid and cleansing agent, is solely on account of its gritty nature, we should prefer its exclusion from tooth powders in general, and recommend it only in exceptional cases.

Greater care in the revision of the proofs would prevent such mistakes as *periostiteal, creta, precipitata, active gumboil, anasthesia*, and *to be used as directed* for several of the mouth washes.

Sport.

Cricket.

GUY'S 3RD XI. v. CHRISTCHURCH "A."

Guy's 3rd XI. ended a very successful season by winning their last match by 24 runs. Of the eleven matches arranged, nine were played, of which seven were won and two lost. The success of the team was due to the good bowling of Russell, Miller, Noyle and Bartlett, combined with consistent batting by most of the team. Fox batted well all through, though he was only once able to secure a half-century. The keenness of the eleven speaks well for future success. Scores—

CHRISTCHURCH.

A. Smith, b Russell	3
C. Brooks, c Miller, b Bartlett	19
E. Morrison, run out	12
F. Culvert, b Bartlett	1
W. Marshall, b Russell	0
— Kent, b Bartlett	5
W. Newman, c & b Russell	4
F. W. James, b Bartlett	2
C. Holiday, run out	0
G. F. Reid, not out	7
— Baxter, b Bartlett	2
Extras	5
Total	60

GUY'S.

F. N. Fox, run out	14
F. C. Robinson, lbw, b Brooks	7
H. H. Moyle, b Newman	9
W. H. Miller, b Smith	1
G. N. Bartlett, c Reid, b Smith	4
A. Vernon Taylor, c Smith, b Brooks	2
G. Russell, b Newman	24
— Wight, b Smith	0
A. M. Benett, run out	0
Roy Ellis, not out	3
Extras	20
Total	84

Appointments.

CIVIL.

GALABIN, DR. A. L., has been selected by the Royal College of Physicians of London as an Examiner in Midwifery for the ensuing collegiate year.

GOLDING-BIRD, MR. CUTHBERT H., has been re-elected on the Court of Examiners, Royal College of Surgeons of England.

HUNT, ERNEST, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Kingsteington District by the Newton Abbot (Devon) Board of Guardians.

PERRY, DR. E. COOPER, has been selected by the Royal College of Physicians of London as an Examiner in Materia Medica for the ensuing collegiate year.

POLLOCK, JOHN ROBERT RUSSELL, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health of the Tiverton (Devon) Rural District.

STEINHAEUSER, J. R., M.B., B.Sc. Lond., has been re-appointed Medical Officer of Health for the Borough of Lewes.

NAVAL AND MILITARY.

SURGEON GEORGE ERNEST DUNCAN, R.N., has been appointed to the Royal Marine Depot.

LIEUTENANTS V. J. CRAWFORD and H. SIMPSON, R.A.M.C., are promoted to be Captains. SURGEON-CAPTAIN R. J. BRYDEN, 1st Kent Royal Garrison Artillery Volunteers, and SURGEON-CAPTAIN ST. C. B. SHADWELL, M.D., 1st Volunteer Battalion the Essex Regiment, are promoted to be Surgeon-Majors.

The operations against the Mahsud-Wazaris on the North-West Frontier of India having been brought to a close, Major-General Egerton, commanding the force employed, has submitted a report to the Government of India, in which, we are glad to note, LIEUTENANT HARRY DIAMOND PEILE, I.M.S., is amongst the officers selected for special notice.

Births.

COOPER.—The wife of Charles E. Cooper, M.B., Ivybridge, South Devon, of a son.

LISTER.—On August 24th, at her mother's residence, Winstead, Honor Oak Road, S.E., the wife of Dr. Thomas Lister, of Brook Street, of a daughter.

Marriages.

EDWARDS—NORMAN.—On the 21st inst., at St. Clement's Parish Church, Jersey, by the Rev. C. W. Balleine, Rector of the Parish, William Howard Edwards, L.R.C.P., M.R.C.S., elder son of the Rev. T. E. M. Edwards, of Trevone, Knollys Road, Streatham, to Nan, only daughter of the late Francis Norman, Esq., of Davisonerie, Jersey, and Mrs. Norman, Hamptonne, St. Clement's, Jersey.

GARNER—STAGG.—On July 31st, at St. Paul's Church, East Molesey, Surrey, William Langham Garner, B.A., M.B., B.C. Cantab., to Helen Mary Cowley, eldest daughter of the late William Stagg, of Motherby, Cumberland.

Death.

HOWSE.—On August 1st, at Walmer, Elsie Sybil, eldest daughter of Henry Greenway and Alice E. Howse, aged 19.

ED.—A. P.

Contents.

	PAGE
ON CARIES OF THE TYMPANIC OSSICLES: Clinical Lecture by Mr. C. H. Fagge	349–354
PAPERS BY GUY'S MEN	354
TWO CASES OF LAPAROTOMY UNDER EUCAINE; ONE SHOWING THE BENEFIT DERIVED IN A CASE OF TUBERCULAR PERITONITIS	354–355
ON ILLUSTRATIONS OF OPTIC NEURITIS AT PRESENT IN THE WARDS	355–356
THE RED LINE	356–358
CORRESPONDENCE: Guy's Hospital Reports	358
NURSING NEWS	358
PASSIM	359–361
MY FIRST OSTRICH	362–366
REVIEWS	367
AN INVESTIGATION OF THE CONSTITUENTS AND ANTISEPTIC PROPERTIES OF ODOL	367–368
APPOINTMENTS	368

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

Sept., 1902.

Sat. 13.—Messrs. Symonds and Steward's take-in; Drs. H. B. German and B. W. Lacey; Cl., H. A. Cutler.

Mon. 15.—First and Second M.B. Durham Exams. begin.
Last day for sending in Fees and Certificates for Camb. D.P.H. Exam.
Names of Candidates for Entrance Scholarships to be sent to Medical School Office by this date.

Tues. 16.—Application to Medical School Office for Schedules for First and Second Conjoint Exams. to be made not later than this date.

Thur. 18.—Messrs. Lucas and Lane's take-in; Drs., C. H. Reinhold and F. H. Wallace; Cl., N. N. Houghton.

Mon. 22.—Last day for applying to Registrar for Form of Entry for Final M.B. Lond.

Tues. 23.—Third and Final M.B. Durham Exams. begin.
Exams. for M.D. and M.S. Durham begin.
Exams. for Entrance Scholarships begin.
Application to Medical School Office for Schedules for Final Conjoint Exam. to be made not later than this date.
Exam. for Medical Entrance Scholarship begins.

Thur. 25.—Messrs. Golding-Bird and Dunn's take-in; Drs., F. Hardy and H. O. M. Beadnell; Cl., C. J. Pinching.

Sat. 27.—Students' Number of the GAZETTE issued.

Guy's Hospital Gazette.

SEPTEMBER 13, 1902.

On Caries of the Tympanic Ossicles.

CLINICAL LECTURE BY Mr. C. H. FAGGE,

July 14th, 1902.

GENTLEMEN,—One of the very commonest diseases existing wherever there are children, especially among the poor, is middle ear suppuration. In some recent statistics, published in a paper by A. H. Cheatle, brought before the Otological Society last session, it was shown that of 1,000 School Board children as many as 335 were suffering or had suffered from this disease. Such cases when they have continued for a certain time will be brought to you for treatment, and so perhaps it will be useful to examine a series of them together, and try to establish some method in their treatment.

CASE 1.—A male, aged 23. Has had ten years right sided otorrhœa since measles; discharge is only marked occasionally, about once a month; is occasionally troubled with giddiness and has treated the disease spasmodically. On examination of the right ear the 36-inch watch is not heard even on contact; bone conduction is increased; on the right side there is a large posterior perforation in which the head of the stapes is exposed: a pedunculated mass of granulations is seen springing from the tympanic floor. After six months' antiseptic treatment by means of instillations of Hydrogen Peroxide and syringing with Carbolic lotion 1 in 60, and Formalin 1 in 500, the malleus, incus, remains of the membrane and the outer attic wall were removed in May. At the present time the middle ear is dry, except for a small granulating area on the inner wall of the middle ear.

CASE 2.—A male, aged 54. Has had deafness and discharge from both ears for at least 25 years which have been spent in South Africa. His trouble, which followed a cold, has recently been associated with rather more discharge which he regards as quite unimportant. He wears a pair of American ear drums which

when removed by me, were soaked in very foul pus. They made little difference to the hearing. Hearing with the 36-inch watch was only on contact in both ears; bone conduction increased. On examination of the right ear the whole of the membrana tensa is destroyed; the head of the stapes is exposed, and the handle of the malleus is truncated with caries. I think in this case, as in the first, from the exposure of the stapes which should articulate with the descending process of the incus, we are quite justified in arguing that the latter is destroyed by caries. On the left side there is a posterior inferior perforation. Three weeks after first seeing him the left ear was dry under antiseptic treatment, though the perforation had not healed. The right ear was as before, and the position being put before the patient, he consented to the removal of the malleus and incus. This was recently carried out with removal of the remains of the membrane and of the outer attic wall. The operation is too recent for judgment as to the result.

CASE 3.—A male, aged 35, was seen for recent suppuration in the left ear, but the right was the more interesting. Seven years previously, when mining in South Africa, he lost his right eye and hearing in the right ear in an explosion. He then saw a well-known aurist but no treatment was advised. He has been quite deaf in the right ear ever since, and has never noticed any discharge. He has well-marked phthisis. On the right side the 36-inch watch is not heard with the tuning fork; bone conduction is greater than air conduction; bone conduction is diminished in comparison with the normal. On the right side the whole of the membrana tensa is destroyed; the stapes is exposed, indicating the absence of the descending process of the incus. After seven weeks' antiseptic treatment, the malleus, incus, and outer attic wall were removed in May of this year. The attico-tympanic cavity was dry in three weeks and has since remained so. In this case it is a point of interest to note that bone conduction was diminished, indicating that at least a proportion of the deafness was due to a defect of the perceptive apparatus, that is, the labyrinth, auditory nerve, or auditory centre: probably from concussion or laceration of the eighth nerve due to the mine explosion. Such defect should not be regarded as a contra-indication to operative treatment of the middle ear when, as in this case, it is undertaken rather to cure discharge than to benefit the hearing; but it is well to point out in such cases that improvement of hearing is improbable.

CASE 4. — A male, of 25. Was seen in 1899, because owing to right otorrhœa which had lasted twenty-three years he was unable to insure his life. Treatment, however, had been irregular. On examination a large perforation was found in Shrapnell's membrane exposing the neck of the malleus, with erosion of the outer attic wall. No caries was detected with the probe, but after some months' antiseptic treatment without benefit, the malleus was extracted in September, 1899, and the middle ear was curretted. Healing was slow and the radical mastoid operation was suggested, but he wrote in June, 1900, saying he was quite well, and that his proposal for life insurance had been accepted.

CASE 5.—A male, aged 24, complained that as a dentist his breath, which was unpleasant, interfered with his profession. He was conscious of left otorrhœa since measles at six, his discharge only amounting now to moisture in the meatus in the morning. When seen in November, 1899, he had had two attacks of pain in the same summer, followed by the passage of a caseating mass through the meatus. He had used intermittently various antiseptic solutions. In the right ear is a healed perforation in Shrapnell's membrane with erosion of the outer attic wall, which is the method by which spontaneous cure of such cases is occasionally brought about. On the left side there is a large perforation in the membrana flaccida, with pus descending from the attic. Hearing with the 36-inch watch on the right side is three inches, on the left one inch. Seven weeks' antiseptic treatment was of no avail, so in December, 1899, the left membrane, malleus and incus were removed. The descending process of the incus and the head of the malleus showed carious foci. On the fourteenth day, after three packings, the left

tympanum was quite dry; the hearing with the same watch having increased to five inches. Five weeks after the operation the hearing had further increased to ten inches with the same watch, and for conversation and whispering was almost normal. Since delivering this lecture the patient has been again under treatment for the right ear, where the attic disease has again broken out, and pus is being discharged through a large perforation in Shrapnell's membrane. The left ear remains quite dry.

Case 6.—A female, aged 36. She has been troubled since twenty with intermittent discharge from the right ear. Four years ago she had a "cerebral" attack, and was kept in a nursing home for some weeks under observation. The left ear discharged for a few months when twenty and again four years ago. On the right side a pedunculated polypus is seen projecting through a perforation in Shrapnell's membrane, which was apparently blocked by the stalk of the polypus. Owing to the chronicity of the disease, and to the suggestive history of threatening intracranial complications some years before, milder methods were not deemed advisable, and the radical mastoid operation was performed last January. The antro-attico-tympanic cavity was healed in the middle of March.

Case 7.—A male, aged 25, has been deaf in the left ear for ten or more years, with discharge. Treatment has been intermittent. He has suffered from occasional headaches. On examination of the left ear a large postero-inferior perforation is detected. Granulations spring freely from the mucous membrane lining the middle ear, and the probe passes up into the attic under the posterior malleal fold. Though almost the whole of the membrane is destroyed, no trace of the incus is to be seen or felt. I merely mention this case because, though he has every reason to appreciate such a lesion at its true value, and has been under antiseptic treatment without operation for two years, his discharge remains much as before.

Case 8.—A male, aged 21. Had left otorrhœa since typhoid at thirteen with much headache. The 36-inch watch was only heard on being firmly pressed against the pinna, and, though bone conduction was greater than air conduction, there was a large defect of bone conduction when compared with mormal. On examination of the ear the meatus was filled with foul pus. No ossicles were seen. The membrane was entirely destroyed. It was argued from the bone conduction being defective that the labyrinth was affected by the chronic suppuration which had probably attacked the labyrinthine bony capsule; so in January, 1891, the radical mastoid operation was performed, after which healing of the middle ear gradually took place.

In reviewing the characteristics common to all these cases, the first point that strikes one is that they are cases of simple uncomplicated chronic middle ear suppuration. Each case was seen because of discharge or deafness, with very little history of headache, pain, pyrexia, giddiness or vomiting, which when present are sure to attract the patient's attention. It is perhaps a curious coincidence that all these cases are adults, the majority of them being persons of the middle class, in whom it is sad to relate familiarity with otorrhœa has induced a contempt for its danger, and in whom one is so often met by the remark "I have no pain," suggesting that some excuse is necessary for seeking further advice. With reference to the frequency of such cases of chronic middle ear suppuration, no statistics are at hand dealing with all classes of life; Cheatle's statistics, previously quoted, deal only with Board School children, but it must be in the experience of everybody that they are extremely common.

With regard to the pathology of chronic suppuration we know little, because it is quite clear that always the primary bacterial invasion will, after perforation of the drum, be obscured by secondary pyogenic infection of the external auditory meatus. In acute middle ear diseases, however, Orne Green has shown from paracentesis in 101 cases, that pure cultures were obtainable in 73 which showed staphylococci in 36, streptococci in 19, pneumococci in 10, bacillus diphtheria in 2, bacillus pyocyaneus in 3, and mixed cultures in 28. Further than this, we have but little bacterial evidence of any prognostic value, though Leutert regards

a pneumococcic milder than a streptococcic infection, thinking its duration less, its febrile reaction less marked, and danger to bone less pronounced. On the other hand, there seems some evidence that extradural abscess is more frequently pneumococcic than streptococcal in origin: thrombosis of the lateral sinus is almost always streptococcal.

It is well recognised, I think, that in almost all cases of middle ear suppuration the root of infection travels from the pharynx through the Eustachian tube to the middle ear.

Coming next to a second point common to all these cases, we find that they were extremely intractable. It is undoubtedly true, as one sees from many cases of cicatricial membranes who deny previous otorrhœa or treatment that many perforations heal spontaneously. In the cases quoted here, no such natural cure had been brought about, and a probationary period of local antiseptic treatment not only did not result in cure, but gave no indication of tendency in that direction; so we must suggest some cause common to these cases for such intractability, and among the common causes we find—

(*a*) Defective drainage, due to position of perforation.
(*b*) Polypi.
(*c*) Small perforation.
(*d*) Defective treatment.
(*e*) Caries.

In the handling of any one of the given cases, *a*, *b*, *c* and *d* are easily avoided. Polypi must be removed, by which means in itself better drainage is ensured; small indolent perforations must be enlarged; and conscientious consistent treatment must be insisted upon. Such precautions being ensured, by what means can we verify a provisional diagnosis of caries of the ossicles in any given case? Here perhaps it would be well to point out a few minutiæ in the anatomy of the middle ear. This cavity is arbitrarily sub-divided by a line drawn horizontally inwards along the superior meatal wall into (*a*) the tympanum proper below, bounded externally by the membrane, and into (*b*) the attic above, which, having as its roof the thin scale of bone separating it from the middle fossa known as the tegmen tympani, and containing the head of the malleus and the body of the incus, is by far the more important of the two parts. The attic is further divided by the head of the malleus suspended vertically by its superior ligament into an inner and outer subdivision, the outer attic being again split up by a ligament connecting the neck of the malleus with the outer attic wall, and forming a space which corresponds externally to the membrana flexida or Shrapnell's membrane; this space is commonly spoken of as Prussak's space. A second recess, lying posteriorly between the posterior fold of the malleus and the horizontal process of the incus (the pouch of von Tröltsch), is also to be borne in mind.

From these anatomical considerations it will easily be seen that suppuration in the attic, because of the peculiar way in which the cavity is sub-divided into a number of small pouches, naturally drains badly, and that any chronic infection of the mucous lining is extremely liable to invade the subjacent ossicles, for you will remember that the two ossicles of which we have mainly spoken to-day—the malleus and incus—depend entirely on the lining membrane of the middle ear for their nutrition. I hope that you are arriving at a conclusion that these cases of otorrhœa are intractable because the attic is invaded and because the ossicles contained in that attic are affected by a chronic carious process, to impress upon you that reliable statistics indicate that in about three per cent. of all cases of otorrhœa the attic is invaded, for it is these very cases which provide a large proportion of intractable suppuration.

Turning to the individual bones, we find that the incus is the bone far most commonly affected. Kretschmann found disease of the incus in sixty-one cases as compared with thirty-eight in which the malleus was affected. Ludwig (Archiv. für Ohrenheilkunde, b. d. 30, p. 24) found the incus carious in sixty-four out of seventy-five cases operated on for suspected ossicular disease. It is difficult to give a reason for the malleus being less liable to invasion than the incus, unless it be that its blood-supply through the vessels of the tympanic membrane is better than the blood-supply to the incus, for

this is the suggested reason that caries of the stapes is so very rare because of its double nerve-supply both from the vessels of the middle and of the internal ear.

In examining a series of pathological ossicles one finds that the long articular or descending process of the incus or its body are the common seats of disease. Destruction of the former is very well shown in the card specimen of the incudes of Cases 1, 2 and 3 which I am now showing you. In thinking of the importance of disease of the incus, one must bear in mind the relationship of its horizontal process to the facial nerve aqueduct and to the passage leading to the mastoid antrum. In the case of the malleus, the head, as in Case 5, or the tip of the handle, as is well shown in the specimens from Cases 2 and 3, are the usual seats of caries.

We must now enquire as to what appearances of the membrana tympani and the middle ear cavity on external inspection suggest disease of these two ossicles. Grunert is of opinion that the following appearances of the membrane indicate disease of the incus:—

(*a*) A large defect of the membrane; no perforation in Shrapnell's membrane; the retracted hammer seen in the remains of the membrane behind and above small granulations or pus, which soon returns when mopped away.

(*b*) Kidney-shaped perforation with pus and granulations above.

(*c*) Perforation behind the hammer involving posterior malleal fold.

(*d*) Fistula in Shrapnell's membrane behind that of malleal caries speaks for isolated caries of the incus.

In caries of the malleus, we find when the head is affected, as first pointed out by Schwartze, a perforation in Shrapnell's membrane immediately above the short process, and when the handle is involved a large kidney-shaped perforation of which the truncated handle forms the centre (Politzer). Any two of these may indicate caries of both ossicles.

If we now study the above appearances of the membrane, I think that in Cases 1, 2, 3, 7 and 8 we should expect caries of the incus, in 4 and 5 of the malleus, and in 6 of both ossicles, and it is on this supposition that the operative removal of these ossicles, with removal of the outer attic wall to assist in drainage of that cavity, was undertaken in most of the cases quoted. However, in giving a prognosis as to the ultimate result as regards suppuration in such a case, the possibility of invasion of the parietal wall of the tympanum must always be borne in mind, for it is clear that such disease, beyond being more easily approached for further treatment by removal of ossicles, and beyond the fact that by this means efficient drainage is secured, cannot be directly benefited by this procedure. The presence of parietal caries can only be made certain by the use of the probe. Its absence can never be decided upon until after operation. Dench found caries of the attic wall in seven out of twenty-four cases in which he performed ossiculectomy.

(In this connection it is worth noting that in Case 1 there has been discovered since the delivery of this lecture a localised carious focus of the inner wall of the tympanum.)

Again, it may naturally be asked, Do such cases get well spontaneously? This must certainly be answered in the affirmative. Natural cure is occasionally brought about by erosion of the outer attic wall, *vide* Case 6 left ear, and Case 5 right ear; but one's common experience as to healing by natural processes in cases of attic suppuration is that it is usually temporary, an opinion which you will see upheld in the right ear of Case 5, in which I pointed out to you the suppuration had again broken out after an interval of some years. Intermittency is one of the characteristics of attic suppuration, and one of its greatest dangers, because it so often leads to its neglect. Another method of natural cure is sequestration of ossicles.

In such cases local antiseptic must always be tried for a probationary period. Instillation of hydrogen peroxide drops, followed immediately by syringing with carbolic lotion 1 in 60 every three or four hours, is a very good method to pursue, but this failing to produce any diminution of pus or appearance of healing after a period of some weeks, or at most six months, we are forced to a choice between two operative procedures—the removal of ossicles as carried

out in Cases 1, 2, 3, 4 and 5, or the radical mastoid operation as in Cases 6 and 8.

In my opinion it is well, when possible, to undertake the smaller operation first, and in most cases to remove ossicles as a preliminary to be followed by the radical operation if the slighter fails. I have pointed out that failures after ossiculectomy do occur chiefly owing to caries of the parietal wall. The largest collection of cases treated by this method to which I have access is that of Grunert quoted above, who found fifty-one cures in seventy-one cases. The risks of the operation are injury to the facial nerve and to the jugular vein, the relation of which to the walls of the middle ear must ever be borne in mind during the operation.

Finally, though I have in the course of this lecture insisted prominently upon the treatment of these cases by this method to cure suppuration and not to improve defective hearing power, it is undoubtedly true that in the majority of cases, as in Case 5, the hearing is decidedly improved, and in a very small percentage indeed is it made worse, otherwise remaining as before. Milligan, in a record of thirteen cases found the hearing improved in eight, and this is not to be wondered at when we consider that chronic suppuration causes defective hearing by (1) interference from secretion; (2) presence of polypi; (3) loss of continuity of ossicular chain; (4) excessive cicatrization; and it is by removal of these hindrances to hearing and the production of a smooth-lined middle ear that ossiculectomy is to be recommended in such cases, if only on account of the betterment of hearing.

Papers by Guy's Men.

The Treatment of Accidental Hæmorrhage. By W. Frank Colclough, M.D., Cantab.—*Journal of Obstetrics and Gynæcology of the British Empire* for August.

Some Points in the Treatment of Fractures. Illustrated. By W. Arbuthnot Lane, M.S.—*The Practitioner* for September.

The Sero-Therapeutic Treatment of Epilepsy. A Criticism. By James W. Russell, M.A., M.D., M.R.C.P. *Birmingham Medical Review* for September.

A Clinical Lecture on two cases of Venous Thrombosis in Heart Disease. By W. Hale White, M.D., F.R.C.P. —*Clinical Journal*, 27th August.

Two Cases of Laparotomy under Eucaine: one showing the benefit derived in a case of Tubercular Peritonitis.

THE chief interest of the first case lies in the fact that operation undoubtedly saved the patient's life and has led to an apparently permanent cure. Subsidiary interest is attached to this case and also to the second, in that both were performed under eucaine.

CASE I.—Hy B., æt. 16, admitted June 4th under the care of Dr. Perry for pyrexia and distension of the abdomen. Previous history good. He had been in the North-Eastern Fever Hospital for nine weeks as a doubtful case of enteric fever. During his stay there he never gave Widal's reaction; his chief symptoms were colicky pains which lessened as the abdomen became distended. Leucocytes 18000. The authorities finally sent him up here as a probable case of tubercular peritonitis.

On admission he seemed desperately ill, pulse rapid and feeble, tongue brown and furred. The breath was of that peculiar and indescribable character that is so often noticed in patients shortly before death. He took no interest in his surroundings and would scarcely speak. The abdomen was uniformly distended; dulness in flanks changing with position, and a thrill shewed that free fluid was present; no lumps felt. Patient complained of constant abdominal pain. No evidence of tubercle elsewhere; tubercular peritonitis diagnosed.

On June 9th, patient was still very collapsed and seemed even worse than on admission. He was taking food very badly; pulse very feeble; apex beat could not be felt. Leucocytes, 30,000; red corpuscles, 2,800,000. Patient was obviously too ill for a general anæsthetic so it was determined to use eucaine. Patient was prepared on June 12th according to the usual regime of compresses and pills. Brandy ʒj. given immediately before operation. Mr. Steward was the surgeon. The patient was prevented from seeing what was going on by means of a towel over an anæsthetic cradle. A 1 per cent. solution of eucaine, previously sterilised, was injected by means of the special eucaine syringe (but an ordinary hypodermic needle would have answered just as well); 40 minims were injected underneath the skin along a line about five inches long; anæsthesia of the skin was complete in five minutes. The abdominal muscles contracted vigorously when cut; no pain was felt until the parietal peritoneum was divided and this caused patient great pain. He drew up his legs and strained with the result that all the intestines were forced out. Replacement of these caused no discomfort so long as the cut edge of the parietal peritoneum was not touched. Four to six pints of clear yellow fluid were evacuated; no tubercles were seen, but a thorough examination was impossible. The abdomen was washed out with hot saline and the wall sewn up in three layers; this caused very little pain. The condition of the patient was good throughout the

operation, which lasted about thirty minutes; the pulse was constant at 104. Cultivation of the fluid remained sterile but there was no doubt about the diagnosis of tubercular peritonitis being correct, simply by a process of exclusion of other diseases. He admitted that he had felt very little pain except when the parietal peritoneum was manipulated and that was no worse than having a tooth out. Half-an-hour after the operation the patient was eating bread and butter and watercress. His temperature, which for the previous ten weeks had oscillated between 99° and 104°, stood next morning at 99°, and only once afterwards did it rise above 100°. His general condition was already better; he had no abdominal pain and soon he began to eat well. Five days after the operation serum began to ooze freely through the abdominal wound and continued to do so for a fortnight. Thanks to good nursing no bad results followed on this complication. Ten days after the operation the temperature was normal and remained so ever since. On July 14th patient was looking and eating well. Massaged daily; weight 95 lbs. From this date he put on 1 lb. every day until he was discharged on August 20th to a convalescent home. He looked in excellent health and could walk a long distance. There was no re-accumulation of the fluid.

CASE II.—James R., æt. 35, was admitted on July 26th, under Dr. Beddard, for a painful swelling in the right iliac fossa. The diagnosis of appendicitis was made and operation advised. Patient disliked the idea of a general anæsthetic but was agreeable to it being done under eucaine On August 2nd patient was prepared in the usual way and had brandy ʒij. previous to the operation. Mr. Steward operated. A sterile 2 per cent. solution of eucaine was used. About 140 minims were injected under the skin along the site of the usual incision for appendicitis. Anæsthesia was complete in six minutes. Patient was extremely nervous and shouted when the skin excision was made because it "felt funny," though it did not hurt him. The muscles contracted vigorously when cut. A 5 per cent. solution of cocaine was painted on the parietal peritoneum previous to division, and when it was divided patient felt no pain. The appendix was found bound down by adhesions and successfully removed. Whenever any tension was put on the mesentery the patient had great pain, but mere manipulation of the intestines gave none. The wound was sewn up in the usual way. There was a little sickness after the operation. Throughout the whole operation the patient was extremely nervous and on the least pressure, not to speak of pain, he called out. Recovery was uneventful. He confessed afterwards that he felt but little pain and cried out only because he anticipated it.

As to the value of eucaine as an anæsthetic for abdominal operations it is clearly useful in cases where the patient is too ill for a general anæsthetic, or where he refuses one. The disadvantages are that it is difficult to gain the patient's confidence and to induce him not to move nor call out until he has actual pain; also it makes the operation more difficult for the surgeon as the muscles remain rigid and contracted.

An interesting point is brought out, though of course known for a long time, and this is, that it is only the parietal layer of the peritoneum which is sensitive. This parietal layer seems to be even more sensitive than the skin, a fact which people repeatedly tapped for ascites confirm when they say that they feel the most pain not when the trocar goes through the skin but just immediately before the fluid comes.

T. H. B. DOBSON.

On Illustrations of Optic Neuritis at Present in the Wards.

AT the present time there are several cases of optic neuritis in the wards which serve to illustrate the various forms under which we may meet this condition, and I propose to briefly mention these cases under their proper heading, with a description of the chief points which may be seen in each.

We will first take the inflammations of the optic nerve and for the sake of clearness adopt a somewhat arbitrary clinical classification and call the three chief sites—

1. Intraocular.
2. Retrobulbar.
3. Intracranial.

1. Intraocular or papillitis—

(*a*) Due to a descending retrobulbar neuritis under which heading an illustration will be given. Such is usually slight in degree and most commonly manifested only by a congestive redness of the disc.

(*b*) The more common form which we call choked disc. This is most often due to—

(i) Tumours of brain, meninges, or cranial walls. In cerebellar tumour it is usually an early and prominent symptom.

(ii) Chronic inflammations of meninges. Tubercular and syphilitic.

(iii) Other rarer causes, such as septic meningitis, cerebral abscess, hydrocephalus, Bright's disease, chlorosis and wounds.

The characteristic appearances in this condition are well illustrated by Stephen 17. This man is suffering from cerebral syphilis and his ocular condition points to a chronic meningitis.

The disc is swollen above the level of the surrounding retina (·3m), it is of a pinkish hue and the vessels on it are blurred (the lâmina cribrosa is invisible) and markedly curved when running over its edge to the retina.

We may compare with this man the case of Philip 11, a man also suffering from cerebral syphilis; here,

however, the changes are probably primarily vascular and due to a syphilitic endarteritis.

He has a large well marked physiological cup, the disc is pinkish and slightly swollen, the vessels narrowed. There are whitish streaks along one or two of them which are partially occluded.

A somewhat similar case in a later stage is Philip 20, in which the patient is a boy who has suffered from cerebral symptoms, which may be due to meningitis or abscess. The disc is swollen and the margins indistinctly striated and lighter in colour than the rest. The vessels are tortuous and bent as they run off the disc; the veins are darker than normal. There are whitish patches over the retina, which are probably due to an old exudative retinitis.

In this connection it will be worth while to examine Mary 33, a woman suffering from ataxic symptoms. Her discs, besides being slightly swollen, have a distinctly greenish centre, characteristic of old congestive vascular change.

Mary 36 is another case of post neuritic atrophy, with, however, no especially characteristic features.

2. Retrobulbar neuritis. This form is usually recognized more by its clinical symptoms than by the appearance of the disc. The most common examples are those caused by tobacco or alcohol, and are characterised by a loss of central vision, mainly evidenced by a loss of appreciation of red and green. In the early stage the disc is sometimes slightly red, especially on the nasal side where the papillo-macular bundle of nerve fibres reaches the retina.

There is a case in Barnabas (No. 11) which may possibly be due to tobacco. In it we may observe that the disc is reddish towards the nasal side. The patient has a small, absolute scotoma for red.

3. Intracranial neuritis. Little is known of this condition independent of more distant lesions, such as meningitis or tumours, which have already been considered under intraocular neuritis; but we may say that it is recognised more by its clinical symptoms, such as blindness, than by any objective signs; but, if any papillitis is present, this is due either to direct extension by the nerve or increased pressure acting along the sheath of the nerve.

We now come to optic atrophy, which we may divide into four groups:—

1. Post neuritic.
2. Simple.
3. Hereditary.
4. Associated.

The last two are unimportant in general practice, so I shall pass them over, especially as there is no case of 3 (as far as I know) in the hospital, and only one, an atypical case of 4, which has an atrophic disc associated with retinitis pigmentosa. We are, therefore, left with two large groups of cases—post neuritic and simple atrophy—and before giving examples of each we will discuss the main features by which they can be distinguished on general and ophthalmoscopic examination.

SIMPLE.	POST NEURITIC.
Presence of one of the causative diseases, such as locomotor ataxia, lateral sclerosis, or general paralysis of the insane.	History of old intracranial trouble.
Disc is greyish or bluish white, with a mottled appearance due to pores of lamina cribrosa being visible.	Disc is uniform and white.
Disc slightly cupped, and physiological cup (distinguished by its only occupying part of disc) still present.	Disc not cupped; physiological cup filled in by the inflammatory matter.
Margin sharp cut and regular.	Margin may be blurred and irregular.
Vessels normal.	Vessels diminished in size, with white lines along larger vessels.

In late stages it is worthy of remark that a very late post neuritic may simulate a simple atrophy.

Mary 16 is a well-marked case of post neuritic atrophy. The discs are slightly raised, whitish and uniform in colour, the pores of the lamina cribrosa not being visible. The margin is less clearly marked than normal, and there is a history of cerebral abscess. The vessels are markedly diminished in size, with white lines along some of them.

I am not aware that there is any case at present in the wards which illustrates a simple atrophy; it would, however, be easily recognised by the history and the characteristics which have already been mentioned under that heading.

I am indebted to the kindness of the physicians for permission to examine and refer to cases under their care.

W. H. BRAILEY.

The Red Line.

THERE are yet places in England where there is real solitude; where, despite the inroads of the busy railway, men live and die with only a local knowledge, only a local interest, and only a local memory. There one finds miles and miles of bleak and dreary moorland, intersected irregularly by sluggish streams, lazily rolling onwards to the great unknown of the vast ocean. There the villages are few and scattered, and the weary traveller plods onwards for miles before even a cotter's hut looms in sight to break the endless monotony. Marsh there is, and treacherous bog, deceiving even the scraggy sheep who browse hungrily on the barren waste.

I had been "doing a locum" in a small village in just such a country as this, and had that afternoon ventured on a bicycle ride, trusting to my intuition of locality to bring me back to the village. It was November, and the

short afternoon rapidly darkened into twilight, and it was only when the blood-red rays of the setting sun lit up the clouds far down in the west, that I realised that I had lost my way, and that night was fast settling on me and on the lonely moor. I lit my lamp and rode on rapidly along a fairly definite road, trusting that luck would send me some guide. I rode rapidly, too rapidly, for a foot-deep rut sent me and bicycle clattering in a heap on the roadway. Personally I was not hurt, but the bicycle was useless as a carrying machine, and I realised that I had no alternative but to re-light my lamp and trudge along on foot. I suppose it was about seven in the evening when a welcome light came in view a long way ahead. The monotonous level of the moor permitted me to see some miles in advance, so it was nearly an hour before I stopped at a tiny cottage, from whose kitchen the welcome beacon had shone. I knocked at the door, and was received by a sad-faced woman of about forty, dressed, as far as I could judge, in rusty black, with a clean white apron covering her skirt. The kitchen was neat and bright; in the open grate a cheerful fire burned, and seated in an old-fashioned arm-chair in a corner of the chimney was a man gazing moodily at the hearth. All this I took in at a glance, photographed as it were on my memory, and as I write the vision comes back as distinctly as if I still stood on that bleak moor, holding my bicycle and looking in at the doorway. I explained rapidly the situation, and received the unwelcome news that I was quite five miles by the shortest route from my village. But the goodwife added that her husband—and here the man looked up from the fire for a moment—was going into Merling in half an hour and would doubtless be pleased to guide me. As she finished speaking the man arose and walked slowly towards me. He was roughly of middle age, quietly dressed in clothing that was superior to the usual garb of the working classes, clean shaven and iron grey. But his eyes, they were the features that at once rivetted my attention. I have never in my life seen a more pathetic, a more hunted look in any man's eyes. They seemed full of some hidden agony, some half revealed horror, that made my heart ache as I watched him. He walked slowly to the doorway, without speaking a single word, and then stopped short. His eyes, which had been directed towards me as he approached were now dropped, and he appeared to be gazing intently at the little patch of light shed from my lantern. "It is the red light, sir," said his wife, in a tone that suggested a complete explanation. "Will you please to put out your lantern and come in." When I had obeyed the man appeared to master himself, with an effort, and civilly gave me good evening. I explained to him the dilemma in which I stood; that I was the doctor in Merling and that it was imperative that I reached home that night. I added that I believed he was due on the same errand and that I should be glad of his company. At this he said "Quite right, sir," and without further ado made haste to don a thick coat, and pulling a cap over his ears, signified his readiness to start. I struck a match and would have rekindled my lamp, but with an earnestness the intensity of which was almost painful, he said quickly, "Not that, sir, not the light." So we went out in darkness, and leaving the main road were soon tracing a narrow path in the direction, as I judged, of the south. We walked in silence for about a mile, and then the increased weight of my bicycle told me that we were ascending a slight incline. At the summit a row of faintly glittering lights came into view, barely visible in the thin haze. He spoke for the first time. "That is the factory, sir," he said, and I noticed that he was free from the local tone and that his voice was suggestive of an education uncommon in a man of his standing. He explained that the lights marked an explosives factory and that he was employed therein. "Do you know anything about cordite, sir?" he asked. I confessed my complete ignorance and requested further information. It appeared to be a subject on which he could be almost eloquent, and he gave me a very lucid account of the manufacture of the nitroglycerine and guncotton used in this explosive. He himself was a nitroglycerine hand, and his duty consisted in sitting in an upper room in the house where the nitroglycerine was made. In front of him would be the upper part of the huge lead "egg" in which the acid and glycerine were mixed by compressed air. A large thermometer stuck out of this receptacle and on it was ruled a red line, which indicated the danger temperature of the mixture. When the mercury rose above this an explosion was imminent and it was his duty to warn a man in the lower chamber who shut off the supply taps and let the contents of the "egg" flow into a pond just outside the house. That was all his work. Just to announce by the pressure of an electric button to the man below, and to the works in general by a duplicate wire, that the danger temperature was reached and then to run for his life along a narrow platform leading to a gap in the earthwork, by which the nitrating house was surrounded. The man below had a similar exit, and it was calculated that both would be able to get some way on the road to safety before the charge went up. All this he told me with a quiet graphic style that was very convincing. Then he suddenly turned his face towards me and asked if he had heard aright and whether I was a doctor. I told him that it was so and then he resumed his onward trudge for five minutes or so in absolute silence. Then he spoke again. "Perhaps you will understand me, sir; the others only nod their heads and whisper. But you will understand me, sir. Did you notice that your lantern seemed to freeze me? Did you hear my wife say it was the red light? It is always that way when I see a red light, or a red bit of cloth, or red anything. It is the red line on the thermometer again, and I cannot take my eyes off it. I cannot; I cannot; my God, what shall I do?" His voice rose in almost an agony, and I thought at first he would burst into tears. Then he resumed again, and his voice once more sank into the mournful tone of his previous conversation. The red light fascinated him. It held his gaze and made

him incapable of action, and he supposed it was the long watching of the red line of the thermometer that had so affected him. He had been at the work now for seven years, and the mercury had never once risen above the danger level. Oftentimes it had quivered just below the line, and three times it has stopped just on the line. Two of these three times had been in this last month, and he wondered if the mixing had been wrong. There was a new foreman. . . Then he broke off again, and his voice rose in a wail of agony. "They are too close, too close. I told the manager so many times and he only laughed. There is No. 3 Filling-room, sir, with sixty hands—men and boys—working in it, and if the charge went up, every soul would be killed. They are too close and the manager only laughs." He wrung his hands in anguish as he spoke and then walked on in silence for a while. After a time he began again, first prefacing his remarks with the question, "You are a doctor, sir?" "Those fits of mine, with the red light, sir. When they are on me I cannot move, and suppose it was so when the mercury went over the line. Oh, my God! my God! and they would all die, and their deaths would lie at my door. It is too awful, too awful. To hard for one man to bear, sir. Sixty hands, sir, men and boys close to Nitrating House, No. A. And suppose I did not give the alarm. Oh, my God!" I spoke kindly to the man. I told him that he was overstrung, and that he wanted to have a quiet holiday away from his work. I promised to speak to the manager on the morrow, and get him away from the red line which worried him so. He listened patiently to me, and thanked me quietly for my promised help. As by now we had reached the village, he wished me good-night, and waving aside my proffered thanks, plunged once more into the darkness. I found a note awaiting me in my house, and after a hurried meal once more set out on the road. Fortunately, I had not far to go, and my call, a midwifery case, was completed by midnight. I must confess that the work I had just done drove all thoughts of my morose friend and Nitrating House No. A. from my head, and I soon dropped into a deep, untroubled slumber. The next morning, after breakfast, I had rather a long round to make, so that it was nearly two in the afternoon before my horse entered the village. We were on the side of a gentle rise, and my house stood on the summit. It was very evident from the number of villagers in the roadway and from the excited conversation that reached me in scraps, that something out of the ordinary had happened. At the top of the hill I stopped, and from my seat in the dog-cart saw the cause of the excitement. Far away in the distance hung a huge, deep-red cloud, and it wanted little explanation to connect it with the factory. Even as I gazed I heard a clatter of hoofs as a horseman came galloping madly into the village. He shouted as he saw me, and I noticed he wore the uniform of the Cordite Company's watchmen. "Come at once, sir, quick, please. An awful thing's happened. No. A Nitrating House has gone up sudden, and there was no warning bell. The filling-room is just a shambles. Come along, sir, please." The red line!

S.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Hospital Reports.

DEAR SIR,—The remarks in the GAZETTE of August 30th, 1902, which appeared in "Passim," with reference to the Guy's Hospital Reports have led to a serious misunderstanding, viz., that these Reports are to be discontinued. As one of the Editors I beg leave to state that this publication was never in a more flourishing condition than it is at the present time, Volume lvii. is now in the press and more than half of Volume lviii. is ready for publication. I should, therefore, like it to be clearly understood that The Guy's Hospital Reports will be published in future, independently of the Clubs' Union and in the same manner as they were prior to the existence of that Institution.—I remain, yours truly,

J. H. BRYANT,
Editor, Guy's Hospital Reports.

8, Mansfield Street, Portland Place, W.,
8th September, 1902.

Nursing News.

MATRON'S OFFICE.

The following appointments have lately been made:—Sister Surgery (Miss A. E. Jones), Sister of Stephen Ward; Sister Constance (Miss Mudge), Surgery Sister; Sister Lucie (Miss Reed), Sister of Astley Cooper Ward; and Mrs. Strathern Sister of Cornelius Ward *pro. tem.*

Nurse H. Clark left the Hospital on August 29th on completion of her three years' training. Nurse Lewin, Head Nurse in the Theatre, was transferred to the Surgery, and Nurse Savage was appointed Head Nurse in the Theatre.

On August 30th Probationer Milledge was appointed to succeed Nurse Bishopp as Head Nurse in Philip Ward.

Nurse Bryan left the Hospital on September 6th, having completed her three years' training, and Probationer Collie was appointed to succeed her as Head Nurse in Charity Ward.

On September 7th Nurse Boyle left the Hospital on completion of her three years' training to take up her duties on the Staff of the Private Nurses' Institution. Probationer Bennett has been appointed to succeed her as Head Nurse in Cornelius Ward.

Passim.

THIS is the first occasion for many years on which the Prize Day will be held in October; it is also of note in that the Lord Mayor has promised to preside. One of the busiest men in London must be the Lord Mayor, and we owe him much for the interest and support which he has found time to exhibit towards Guy's in a year in which we need it most. Earlier in the spring the eloquent appeal which he made on behalf of the hospital was of very valuable assistance. Now he is again showing his interest in us in connection with the Medical School, and it is to be hoped that all Guy's men, both past and present, who are able will do their best to show him how they appreciate his kindly encouragement by their presence on the 1st prox. Academic costume will, of course, be worn. The Wills' library is to be transformed for the time into a tea room, the band of the 2nd Life Guards will be a guarantee for good music in the grassy space which we so fondly term the "Park," and with luck in the weather we should have as successful a day as any we have enjoyed in the past.

THE library, which is the gift of Sir Frederick Wills and which will add another to the list of our possessions of great price when completed, is now in a condition of metamorphosis. The outer shell which has been used for the purpose of a temporary Nurses' Home, is, as we write, being fitted up internally to adapt it to its new and permanent capacity. We understand that the oak bookcases and panelling with which it is to be adorned will be worthy of the best traditions of College libraries, and it may be confidently expected that it will be ready for use by the end of the Winter Session.

IT is with much sorrow that we have to chronicle in this issue the sad death of Mr. George Thomas Collins. At Guy's, where his earnest, quiet and unassuming character had made him deservedly popular and had won him real friendships, his early decease will cause many pangs, the keener for the suddenness of the blow. Thorough and hard-working in every way, he never had much difficulty with examinations, and in May, 1901, he took his London degree in Medicine. Soon afterwards, as a civilian surgeon, he went out to swell the ranks of the Guy's men who were already at the front. There he travelled much about the country, and amongst his other experiences he enjoyed that of making the acquaintance of the Boer Peace Delegates. In July of the present year he returned to England, and to the many who welcomed back his bronzed and healthful face it is difficult to realize that he is no more. In August he entered the R.A.M.C., passing into the service eleventh on the list. Shortly afterwards he was struck down by the attack of enteric fever to which he succumbed on the 31st of the month. There can be no doubt that a brilliant career lay before him in the service which he had elected to join—a service in which his sterling qualities would have had fair scope. We take this opportunity of conveying to his family our very deep sympathies with them in the heavy blow which they have sustained.

THE Students' number of *The Hospital* contains an editorial article which can scarcely be allowed to pass unchallenged. The writer assumes a very curious mental attitude to exist amongst the present-day practitioners of medicine, and goes out of his way to suggest to the newly registered student various little devices by which he may emancipate himself from the shackles of his future brotherhood. There is too much science in modern medicine—too little rule of thumb. The present-day student is forced to learn the condition of the human being as an ordinary healthy animal before he is allowed to study him as a pathological curiosity. Consequently, *The Hospital* believes, he loses the nicer sensibilities, the keener sympathy and the more earnest attentiveness that marked the old-time practitioners. "The object of medicine is not so much to cure diseases as to treat patients," and with this extraordinary recommendation to a life of superficiality, *The Hospital* passes on to the necessity of having a good presence and decent

manners. We sincerely hope that no one will be so foolish as to follow the advice given in this curious article, and to cultivate the pernicious and senseless habit of treating symptoms and symptoms only.

THREE hundred and twenty was the number of the patients registered in the Front Surgery book on the busiest day of last week. This is an amount of work which may be calculated to keep the 'cutest and most rapid diagnostician actively employed from morning to night. At this time of year a very serious addition is being made to the normal daily toil by the closing of the Evelina Hospital. An extra forty or fifty patients does not sound alarming, but when the surplus takes the form of so many screaming infants, its moral effect reaches far. To go into the front about 12 a.m. on a Monday morning and watch the Assistant House-Surgeon struggling patiently amidst the heaving, howling throng, here listening to some mother's tale of woe, there vainly attempting to convince some violently abusive female that she cannot be taken in for a cut finger, is to come away and feel that he is a better man than yourself.

IT is a pity that we have not the luxury of a leaded display bill. Much alliterative attraction might be evolved from the frequent ptomaine poisonings which have visited the hospitals of late. The poisonous pork-pie, the baneful bloater and the wicked winkle have all served to swell the numbers in our attendance book. It is no uncommon thing for an H.-P. to be hurriedly summoned to treat a corrugated consumer of mussels, who shows a marked proclivity to tear himself to pieces. Children, who are fed on the best principles of Borough dietetics, vomit and die with distressing frequency; their friends and relatives of adult age usually react to buckets of lead lotion and prodigious quantities of white mixture. And, meanwhile, the itinerant vendor of stale shellfish grows fat on his nefarious earnings and a rigid animal diet.

ONE is accustomed to hear occasionally of little hoards which organ-grinders, beggars and other riff-raff save up from the proceeds of their lucrative employments, but it is not often that the Front Surgery reveals so much glittering wealth as was found last week on a certain comatose Italian; one hundred and ten pounds in gold was the sum, and it seems extraordinary that one of his sober race should rush into what is usually known as a "paralytic blind," with the knowledge that all his wordly wealth was concealed upon him in an easily portable form. Still, "Homeward Bound" means a lot, and is celebrated by each in his own way, and this good man's ticket for Rome was upon him.

A TRUE story, which is not without its humorous touch, comes from the Surgery. A certain mother brought her child to be examined, and demanded to see Dr. ——. An attempt was made to convince her that this doctor was not available, but merely met with a reiteration of the request. She was then asked why she was so anxious to see this gentleman and no other, whereupon she replied, "Well, you see, 'e understands the constitootion of the family so well; 'e give me the certificates for all my other three children what 'ave gone to 'eaven."

THE predominance of rain lately has impressed upon us the fact that it is the holiday season. Everybody is away, and everybody is present in deputy. House-physicians and house-surgeons have snatched brief respites from the labours of their wards and sought recreation and health in the excitement of rain-locked seaside lodgings. The work has gone on just the same, and it has come as a painful blow to their *amour propre* that we have not shut down the place in sheer inability to do without them. Ofttimes it would be difficult to know that they were not there; such is the ephemeral might of the house-physician. On the staff, too, there has been the same lieutenancing, and many parts have been doubled by one man who has, by dint of constant and continuous attendance in theatres and wards, succeeded in keeping just in front of the work in hand. Which proves the value of the saying that you never know what you can do till you try, or are tried.

OWING to the kindness of the Earl of Pembroke, an addition was made the other night to the modest meal of the Residents. A supply of venison had arrived a few weeks before and had been stored for future use. Daily bulletins were issued, and on Tuesday night operative interference was deemed necessary. In the confined space of the kitchen the cooking operations were rendered comparatively easy, but once the meat was allowed to roam in the dining hall, the work of allocation of portions became increasingly difficult. The herd appeared to murmur strong disapproval on its entry, and required much skilled droving before it could be carved. Further coaxing was necessary before it could be induced to stay sufficiently long on the plate to be served. We have it on excellent authority that the sight of the untamed venison moved many strong men to tears and necessitated their sobbing removal from the hall.

MOST of us at one time or another have deplored the unfortunate craze for test examinations which has settled down in the Medical School Office. We were therefore agreeably surprised to see an official notice in the colonnade the other day which insists, in the most forcible manner, on the folly and wickedness of these banes. The punishment, to us at least, appears excessive, not to say brutal. We give the notice as it appeared—"A test examination will be held on Thursday, September 18th, at 10 a.m., in Class Room No. 1, New Buildings. No student will be signed up for the October Conjoint and Preliminary Science Examination who does attend and pass this examination."

A CORRESPONDENT who signs himself a "Regular Player"—possibly a near relative to our friend the "Constant Reader"—puts in a grumble anent the Fives Court. He alleges that six weeks ago the repairs were commenced and almost completed, but from that date until this the few finishing touches necessary for his complete happiness have been lacking. The doors need catches, the walls netting, and the workmen manners. The last item seems to be the hardest matter with which to deal. Apparently a hitherto unasserted right-of-way lies across the court, and the British workman, who spends so long in the contemplation of his job and the mental selection of his tools, cannot find it in his heart to waste his employer's time by waiting for the completion of a rally. So it is that a well-placed corner stroke strikes an additional hazard in a horny-handed son of toil, and the baffled adversary seeks refuge in the pleasant haven of a "let." We agree with our correspondent that the concrete additions necessary in the court are few, and should be at once supplied. As to the teaching of manners to the bricklayer's labourer, possibly individual coaching by the boxing experts might be of service.

AT a future date we hope to publish portraits of the late Dr. Washbourn and of Mr. Howse, our youngest consulting surgeon. The process by which the pictures are produced necessitates much time and much care; we shall not therefore attempt at present to define any time for their publication. We shall content ourselves by saying that they will be companion portraits to those of the Staff already published.

THE following extract from an Australian paper speaks for itself. The Colonies seem to be striking out new lines for themselves everywhere, even in medicine:—

SICKNESS AT BOGO GULLY.

Mr. James Smith, of Bogo Gully, who has been very low with peurperal (*sic*) fever, is now recovering. Miss Dooley, of Bogo, has also been ill for the past weeks with congestion of the liver, but is now recovering both under Dr. O'Mick's care.

THE clinical lecture by Dr. Bryant which was published in the last number of the GAZETTE is a reprint from a past number of the *Clinical Journal*, to the editor of whom we tender our acknowledgments for allowing us to reproduce it.

My First Ostrich.

THE story of my first ostrich is not a pretty one, and as I review the details in my mind, it seems to me that the less I speak of it the better. The crooked paths of deception, and the lies into which I cannot deny that I was led, impress me as being rather the blacker than otherwise for the success with which they met; and yet there is a humorous side.

It was in the early African summer, when the snakes were commencing to wake up from their winter sleep and wander forth ravenous, and the tarantulas were already beginning their rapid bush to bush visitations; old earth was alive with a new life, and a ride through the clear bright air of the karroo was one of those joys "whose memory never fadeth."

One afternoon a new delight was presented to the camp by the news that a few great "pauw," the largest bustard in Africa, had been seen in the neighbourhood.

There were several amongst us who looked upon themselves as sportsmen, and some there were whose experience had been wide and varied, but not one of them had obtained a specimen of the great pauw.

As they grow scarce these birds become correspondingly wild and difficult to approach, until at present a chance at a hundred-and-fifty yards with a rifle is one which seldom offers itself to their would be destroyers.

The difficulties in the way of getting a specimen greatly enhance the value of the skin, and accordingly we made up our minds to obtain one.

There were in all four of us who met and formed the following simple scheme:—The land on which the birds had been seen was, roughly speaking, a circular plain of some five or six miles in diameter, and almost completely ringed in by the usual African kopjes of varying height. This lay immediately behind the camp, and we were to divide into two parties; B—— and myself were to enter the plain from the eastern side, whilst S—— and P—— were to ride some three miles round to enter from the west. Their road was longer and more difficult, lying for the last mile along a deep valley where the karroo bushes were thick, and the ground rough, so we gave them half an hour's start.

I remember that as they started off we made some foolish jests to the effect that we would make it a point of honour as to who should obtain an ostrich in the event of our failing to find the pauw. We ourselves started full of expectation, B—— armed with a sporting Martini-Henry, and myself with a short sporting ·303 carbine. We were both well mounted, he upon a Cape pony, whilst I rode a great Waler, who made up by length of stride and speed for his lack of that knowledge of ground and ant-bear holes, which is so prominent a feature in the character of the native breds. For three miles we cantered slowly westwards until we had surveyed practically the whole of the plain, but nothing could we see either of the pauw, or of our friends from the other direction.

Once we heard a shot, followed soon afterwards by two more in quick succession, and knew they had found something; a slight depression settled upon us at the thought that the pauw had in all probability fallen to the opposition show, and we were thinking of giving them up, when, in an evil moment, we sighted two ostriches pulling at the karroo bush under the shadow of a great kopje. My companion's suggestion that we should race them for the fun of the thing was made to be acted upon, and acted upon it was with a vengeance. An ostrich is a bird with the speed of a forty horse-power motor car but his legs have been developed at the expense of his brain; he is essentially a fool. Sometimes he will make up his mind to go in one direction and nothing will turn him; as often as not this course takes him within a hundred yards of the sportsman. More often, however, he fails to make up his mind at all and merely zig zags to and fro; this is what our pair did. A wild rush to our left for half a mile at a rate which would soon have carried them far beyond our reach, would be followed by an equally indecisive retreat to our right, and so the game went on. We must have raced for over two miles and were driving them into a corner of the kopjes, when they at last made up their minds; with wings wide spread and ten foot strides they struck for liberty past our left. One last gallant effort our horses made and then they swept by us like a pair of storm fiends and the race was over; alas not so the story. Three miles mad race had heated our blood and fired those destructive faculties which makes a man go out to kill, and by this time we meant shooting. Over the horses' heads went the reins and as they stopped dead in obedience off we tumbled in a heap; about four seconds it took us to pull up and aim, and with the sight at three hundred yards my bullet was the first to speed. As the fire leapt from the barrel the cock bird crumpled and fell with a crash; he never moved again. Thirty yards to my left my friend was rapidly planting leaden messengers in a circle around the second bird, who, however, soon disappeared over a ridge.

We were still exulting when we led our sweating, panting horses to the corpse, and then as we looked down at the bird, shot through the heart, it burst upon both of us that we had been brewing trouble. It is true that ostriches are very destructive to the veldt on the karroo; they pull up bushes whole instead of grazing off them as cattle do, and not infrequently a farmer who has a large number of nomad birds upon his land will surreptitiously organise a shoot to drive them away; secrecy is, however, an essential, since the law makes no difference between a nomad and a stay at home bird, and the law ordains a penalty of £50 for the shooting of one, apart from the value of the bird to be paid to the owner of the land. All these things passed through my mind at least, and I knew, moreover, that this was no nomad, but a bird who probably never strayed many miles away, a bird whom the farmer would know and miss.

I looked across at my friend; he wore a quiet smile.

"Well," said he, "what are you going to do about it?"

"Bury the beast," said I, with some vigour.

"It was a good shot," he replied.

I said nothing. I felt that flattery was out of place; mentally I cursed the shot and thought of the ten pound note which constituted my worldly wealth.

"Beautiful feathers," was his next remark.

This was true, and finer feathers I have never seen. He must have been shot at the right time, and we easily decided that as the bird was to be buried we might as well pluck him. This we did and tied a great bundle of feathers to my saddle. Next we cut off his feet as trophies. The next thing to be done was to bury him; it was out of the question to dig a hole, so I sought for an ant-bear hole large enough to hold him with a little squeezing.

If one is riding at full speed after buck, the frequency with which one blunders across a yawning ant-bear burrow of sufficient size to bury a sheep in is the thing which is impressed upon one's mind more vividly than anything else; here, of course, with the usual contrariness of life, there was none nearer than 100 yards, and even that was a small one. However, we each seized a leg and started; half-a-dozen yards exhausted us. Next we thought of lifting him upon a horse; the horse objected strongly and we failed. Then we dragged him another four yards and sat down panting. Then my companion said, "Damn the bird," got upon his horse and rode off. I agreed with him entirely and did likewise.

All this took time, and we had been keeping a bright look-out for intruders, but saw no one. It was about five o'clock and within an hour of sundown, so we decided to ride to the wildest and most desolate part of the hills and divide the spoil, throwing away the worthless feathers. We then calculated upon getting into camp an hour after dark and smuggling them to our tents unseen. We found a tiny green dell dotted with bushes, welcome for their shade, and, turning out a couple of secretary birds who were searching for snakes with the air of the wise men of the East, we sat down for a rest. Five-and-twenty magnificent long white feathers with heavy bushy tips, sixty black beauties, and about three dozen of the little brown tips from the tail, formed the sum total of the profits of our guilty deed. One incident only marred an otherwise successfully secret return; at one spot in the hills, as we rode along a narrow path, we met a Kaffir herd boy, who was obliged to rein his horse up on the side of the hill to let us pass, and who, as we knew, could not have failed to mark the feathers which we carried. We were not Dutchmen so did not think it worth our while to secure his silence with a bullet.

We rode into camp in the starlight, having seen nothing of our other two friends. Entering my tent, I threw down the feathers upon the bed and prepared to think. I was repaid for my foolishness within three minutes, by the sudden opening of the tent door and appearance of S——.

"You have come back at last, I wanted ——. Hallo, what's this?" as he caught sight of the feathers.

"Just been brought over by Liebenberg" I said rather too hastily; "Jolly good of him, don't you think? You remember he promised me some, and he plucked a bird to-day. I never thought he would give me so many though. But you were saying you wanted something?"

"Yes, by jove, what do you think I've done; I'm in a frightful stew about it. I've been wanting to tell you, but could'nt find you."

My silence expressed ignorance of his deeds, but I had begun to suspect, and things were beginning to get complicated.

"Yes," he went on, and peeping out of the door he whispered in a hushed tone—"Yes, I've shot an ostrich."

"Oh!" I said "How the dickens did you manage that?"

"Well, the beggar came up to within four-hundred yards and I loosed at him, never thinking that I should touch him, and he fell all of a heap—'What did I do with him?' Oh! he got up again and skedaddled, but he was hit. I am afraid he will die; what do you think?"

"You may depend on it" I said "that he will die. Ostriches won't stand much, and a wounded bird always dies. What he will do will probably be to go to a nice open spot where everyone can see him, and then he will lie down and die; and there will be a bullet hole in him."

"Then there will be a row."

"Then there will be the deuce of a row" was the only reply I could think of.

"Well, I shall go to the Colonel now and make a clean breast of it," was his next remark, and it dumbfoundered me a bit.

"Oh, I shouldn't do that you know," I said as deliberately as I could, lighting a pipe with the idea of gaining time. "You see he may not die and you might get into trouble for nothing, or he may die in a hole somewhere and never be found. If you take my advice you will lie low, and you can depend on my keeping quiet about it."

I now began to see a new side of S——'s character. He was a most excellent fellow in every way, but he was cursed with a conscience such as I had at the age of ten. It was a sort of constant pricking, urging him to do something, and it now urged him to go and confess. However, I succeeded after half-an-hour's struggle in persuading him to keep quiet, and nothing further occurred that night.

I had a talk over the situation with B——, who did not seem to grasp its gravity. In fact, he was immensely tickled over the whole thing, and, I believe, really very pleased that we had shot the bird. He was a keen shot, and liked to see the bull's-eye hit, and that was the paramount consideration with him for the time. The next day was Sunday, and passed off peacefully without alarm. I began to breathe more freely.

Monday morning at breakfast the second act commenced. The Colonel received his letters and read for some time; then he looked up suddenly—

"I say, you fellows, this is a serious thing. Old Erasmus has sent in a note to me to say that one of his cock ostriches has been shot by two men yesterday afternoon. It appears that one of his herd boys saw the bird shot, and saw the men afterwards. He is extremely annoyed about it, and swears he will have £60 for the bird. Is there anyone here who was shooting yesterday?"

A dead silence. I had a prompting to confess all, but the devil offered me a loophole—it was Saturday I had shot the bird—not Sunday.

"B——, do you know anything about this? Were you out shooting yesterday?"

"No Colonel."

Next he asked me. My defence lay in the fact that as medical officer for the day I had been unable to leave the camp.

I looked round for S——, and noted with much relief that he was late for breakfast, and had not arrived. Early rising and a conscience do not always run together.

The Colonel asked two or three more, and then gave it up. He merely said that he intended to find out the offenders.

An hour after breakfast S—— came to me in great trouble. He had heard all about it, and could not eat his breakfast; he seemed to be ageing rapidly, and his anxiety to confess was as piteous as it was laudable. I could not bear the sight of his worried face, so I sought to relieve his conscientious indigestion in the best way I could. I confessed all to him. To my surprise he was not in one whit the better. He must still go to the Colonel, so he went. His case was summarily dismissed.

"Did you pluck the bird?"

"No."

"Then it was'nt you. Take my advice and say nothing more about your shot. This bird was plucked."

Two more days passed, and various measures were adopted by the Colonel to find out the offenders; the officers' tents were searched to find out who had rifles; that was too thin, and ours of course were elsewhere. Stables were examined, but the error in date confused the deductions from that.

Suffice to say that these two days were days of considerable anxiety to myself, and half serious amusement to B——, and were terminated by discovery, the means of which I do not know even now.

Nothing but the fact that I fully believed that discovery meant ruin, prevented me from revealing all. I recognised that the Colonel must sooner or later find it out, but I thought that the one small chance that he might let it drop might occur; for all I could see to have to pay £60 meant that I must remember something which I had left behind in England, and which I must return to fetch at once.

Well, Wednesday afternoon when I was away from the camp, the Colonel entered into a friendly conversation with B—— as they stood watching a cricket match. Suddenly he swung round on him with—

"B——, did you or X—— shoot that ostrich on Sunday?"

"No Colonel, I said so before."

"Well, did you shoot him any other day?"

"No, colonel, but you're getting warm."

"What the dickens do you mean? Did X—— shoot him any other day?"

"Well, yes, I believe X—— did shoot an ostrich on Saturday. It was a good shot, though."

"Well, you had better let him know that he has got to go and square up with Erasmus to-morrow."

This was the cheering intelligence with which I was greeted on my return. I groaned a little, and went to the mess tent for a brandy and soda. Teetotaller though I am, as a rule, there are occasions when a little medicine, etc.

B——, for the first time, took the thing seriously, and stoutly declared that he had had his fun and was going to pay for the bird. This I, of course, would not think of; indeed, there was not much I could think of. Conscience indigestion attacked me now that I was found out, and I could not eat much dinner. In fact, I felt that I was suffering from all the ailments which I see in the paper can be cured by Dr. Williams' pills.

I went to bed a wreck, and slept like a top for four hours. Then some angel of inspiration must have hovered over my bed, and I woke with a plan ready formed. I thought for ten minutes, and went to sleep again.

In the morning I woke in good spirits, and smacked B—— on the back in vigorous pleasantry. I think he was pleased to see me revived, but he never liked being hit about.

I outlined my plan to him, and he swore a little and laughed more. Then he said he would like to come with me to see Erasmus.

At ten o'clock I saw the Colonel, and informed him that I did not want to put him to any more trouble in the detective line, and that I had come to confess that I rather thought Erasmus had made a mistake, and that the bird about which all this fuss had been made had fallen a victim to my rifle on Saturday.

The Colonel, being a man of elastic conscience, bore no malice, and considered the matter now off his hands. He would leave all the details to me, he said, but Erasmus must be compensated.

I ascertained that to compensate meant to satisfy or soothe, so I developed my scheme. I pointed out, first, that to pay £60 meant ruin to me.

The Colonel smiled, and offered no sympathy.

I next asked him if he would assist me so far as to meet any further letters or visits from Erasmus by an answer to the effect that I had been appointed to investigate the whole affair.

He looked at me rather hard, pulled his moustache, as I thought to conceal a smile, looked at the kopje, and said "yes."

The rest was comparatively easy, and I set off at half-past two with B—— to interview the farmer.

The third act now commenced.

Erasmus was a Dutch farmer of the old style; Dutch to the backbone he was as hard as nails, knew his bible from cover to cover, and could bargain a man's head off. The "slimness" which I intended to practice on him would have been a delight to him had the conditions been reversed, and the certainty of that has been one of my few consolations. His hatred of the English was one of his characteristic points, and as I had already been informed by the colonel, he intended to prosecute to the utmost rigour of the law should he discover that the offender was an Englishman. He was a stern old Puritan without the hospitality that is usually to be found in others of his race in the Colony. Of English he could not speak a word, and this was one of the chief drawbacks in our conversation, since his wife, who acted as interpreter, had a woman's intuition, and was far sharper than himself.

We arrived at the house in the full heat of the afternoon sun, and were admitted at once to the stoep, which, contrary to custom, was on a level with the upper story. As we reached the top step we heard the scurry of Mrs. Erasmus's skirts as she rushed away to arrange her back hair and wash herself, and found ourselves confronted by the old man. The only English he knew was "Good day," and that we soon exhausted; the only Dutch I possessed was the power to ask "Where is the water?" and a few tender passages which I had picked up from time to time. None of them seemed suitable for the occasion, so with the exception of another round of "Good days" at the end of five minutes' silence, the conversation lapsed.

For at least ten minutes we sat in stolid silence looking down at the green foliage of the beautiful old garden below, whilst beyond stretched the bare karroo, dotted with sheep and terminated by the distant blue of the hills. The peace of the scene had no parallel in the depths of my bosom, and I hailed it as a relief when the good lady appeared, followed by coffee.

Immediately behind the coffee came the old man's son-in-law, and as we all sat down I opened fire.

I commenced with the usual compliments, and remarked how glad I was to see him looking so well, etc. I found him a little taciturn. I next remarked what a beautiful garden he had. He answered "Ja," in an uncompromising monosyllable.

Next I tried him on the rains, and said what a good year it had been. This produced the same answer.

An attempt to draw him out by noting how much fatter his sheep were than his neighbours', met with the same result.

Finally, determined to get more than the everlasting "Ja," I asked after his crops. He replied that he hadn't any, and I felt that I was losing ground. Of course, he hadn't; it wasn't the time of year. Small talk through an interpreter is difficult, and I advanced to the business n hand.

I explained that Dr. B—— and myself had been deputed by the Colonel to find out all the details as to the shooting of an ostrich on the farm. I pointed out that the deed was viewed by all the officers with the utmost indignation, that we were determined to probe the matter to the bottom, and had no doubt that our efforts would succeed in unmasking the scoundrels. We now merely wished to ask a few questions.

How much of my somewhat lengthy harangue was understood I do not know, but he became thoroughly alive at last, and for ten minutes he talked unrestrainedly in a tone, which, though we understood not the words, was clearly indicative of threats.

When his purple old face relaxed to scarlet again, and he sank back for a few moments' rest, his wife conveyed to us what we already knew. In short, the old man would be merciless could he lay hands on anyone; my sage remark that it was, so far as I could see, the only course which he could adopt to prevent future outrages was evidently a little soothing, and he offered to answer any questions.

I still have the notes which I made on a nice clean piece of paper.

"Now, Mr. Erasmus, on what day was this bird shot?"

"On Sunday, Doctor." Still the error in the date I was glad to see.

"And the time?"

"At about an hour before sunset."

"Did you or anyone else see the thing done?" This I said with some anxiety.

"Yes, Doctor, my herd-boy saw the bird raced and shot by two men, and he afterwards saw them quite close and carrying the feathers. He would know them again by sight."

Things were getting a trifle warm. We began to wonder a little where this confounded herd-boy was at the present moment, and B—— drew back from the edge of the stoep into the shadow behind, with some remark about the heat of the sun.

I pondered a little and went on—

"Were these men dressed in khaki?"

"I don't know, Doctor, but we will send for the herd boy who will be able to tell you."

I looked at my watch a little hastily and said I didn't know that it mattered much. Of course, everyone in the camp wore khaki, and I only had another five minutes to spare. We would see the herd boy to-morrow. He grumbled a little, and said it would not take a minute, but I passed on hurriedly to the next question. For the first time a sight of B——'s face had induced a strong desire to laugh, and I was getting anxious about his own self-control.

"Now, Mr. Erasmus, you say the bird was plucked?"

"Ja, Doctor, a few of the best black feathers were left, which we will show you."

These were brought forth at once and I passed them to B——, with my eyes on the distant kopjes; I had seen his mouth twitching. "You see, Doctor, they are very beautiful; those which are left are worth a sovereign, and the skellums* have the rest."

* Rascals.

The skellum who held the feathers suddenly buried his face in them, and smelling hard at them as though they were flowers, exploded into a series of grunts.

I explained that that was his method of sneezing, and that he ought not to be out of bed. The wife looked hard at us and said nothing. Then, as the attack passed off, she suddenly turned round on me with—

"The horses were both brown, Doctor, one big and one little. Can you not tell what horses were out of camp on that day?"

I explained that the majority of the horses in camp were brown, and regretted that one of the culprit's horses was not white, when we might easily have traced them. At the same time I began to feel once more the sharpness of the thorns on which I sat; this cute woman had evidently been cross-questioning the boy, and the men might have been more easily described than the horses. A Kaffir's power of noting and describing a man by his chief characteristics is preternatural, and all men are named by them from their appearance.

I thought it time to close the interview; I feared the arrival of that boy.

Accordingly I delivered my final oration. I explained the difficulty of finding a man in a busy camp, whence many departures took place daily in all directions, and I waxed eloquent on the horrors which lay in wait for that man when he was found. At the same time I assumed a philanthropic air, and assured Mr. Erasmus that whether or not the man was found, the officers of the camp were determined that the farmer should not lose by the deed.

At this point Erasmus seized me by the hand and became a true friend; he would have done the same by B——, but the latter was suffering from another of his absurd sneezing attacks.

I then came to real business, and pointed out that in the event of our not finding the man, or of the man being too poor to pay for the bird when found, we should ask Mr. Erasmus to name a price which would pay him for the loss, when the officers would subscribe to raise the sum. He named £10 with a promptness which convinced me that it was too much.

I suggested £4 as the price at which I had seen birds advertised. We finally haggled it down to £6, and said good bye with many expressions of mutual satisfaction and friendship. He hoped to see us over again; we thought of the herd boy, and assured him that we should do our best, but were very, very busy.

As we went out to our horses, we both blew our noses with large handkerchiefs which offered some concealment; that nightmare might appear at any minute. On the way home we fell off our horses at a safe distance and laughed foolishly for about a quarter of an hour, whilst the two intelligent animals observed with mild surprise what fools we were. It was not humorous perhaps, but it was the relief from tension. Just before entering camp we met the Colonel; he was much amused, hit us on the back, and said we were roystering young blackguards; this was one of his choicest terms of endearment. Secretly, I knew that I had played a low trick, but I had not reached my depths.

A week later I wrote to Erasmus, regretting my inability to see him in person, and informing him of the name and condition of the culprit who had since returned to his regiment near Kroonstad. As we found it was hopeless to obtain compensation from the man, we were sending him a five-pound note as a solatium, which we hoped he would have no scruple in accepting. We never heard from him again, but the Colonel was too pleased with the story to keep it to himself, and told the magistrate of the district; this worthy told all the farmers in the neighbourhood, and so it came back to me.

Curiously enough the extraordinary nature of the Dutch colonial is such that I found we had gained in popularity instead of losing, but the many jests which they cracked with me at the expense of poor old Erasmus, always stung me a little, for an Englishman's translation of the Dutch slimness contains hard words.

The feathers, which we kept, were judged by an expert to be some of the finest he had ever seen. They were valued at about £6 to £7, but Providence sent ants to destroy the best, and we accepted the judgment as mild and just.

Reviews.

The price of books submitted for review should in every case be stated.

Lectures on Chemical Pathology. By C. A. Herter, M.D., Professor of Pathological Chemistry, Bellevue Medical School, New York. (Smith, Elder & Co.).

The series of lectures which make up this volume were delivered in the Bellevue Hospital last year, and are now published in their original form. Though a knowledge of chemical pathology is of undoubted value in medicine, this book is not likely to be as widely used by students, whose reading is necessarily limited by the rigid requirements of a syllabus, as by practitioners who have done with examinations and have reached that happy stage when they can select their own literary pastures and linger longer or shorter as the field suits their taste. One would hesitate to insist on this book finding a place upon the already crowded shelves of the medical student, but the practitioner will do wisely to become acquainted with its pages. Dr. Herter has an easy, colloquial style, in expounding the theoretical part of his subject and applies his facts to practice in a manner both lucid and convincing. His chapter on diabetes is particularly good, well repaying perusal, while his discussion of side-issues arising from questions he handles is always interesting—such, for instance, as the abuse of alcohol. He certainly comes to a very safe conclusion

when he maintains that the practical objections to the use of alcohol have little to do with the vexed question whether alcohol is or is not proteid-saving.

Physical Diagnosis. Gibson & Russell. 3rd edition. 435 pages. Price . (Young J. Pentland). In this new edition many new chapters have been added and the book has thereby been much improved. The sections on the "Blood," "Gastric Contents," and "Clinical Bacteriology" will be found to be especially useful. The illustrations are excellent.

A Text-book of Physics. R. A. Lehfeldt, D.Sc. 299 pages. Price 6s. (Edward Arnold.) This book has been designed, according to the preface, especially to meet the wants of the medical student. It is clearly written and appears to fulfil its purpose in that it covers the ground without being too intricate.

An Investigation of the Constituents and Antiseptic Properties of Odol.

For some time past, Odol has been much discussed. This dentifrice exercises the curiosity, and awakens the interest of all who are engaged in dental surgery; and everyone is aware that the most singular assertions have been made concerning it. Some hold Odol to be nothing more than scented creoline. This view is completely erroneous. A German chemist has come nearer to the truth; he considers Odol to be a mixture of essence of mint, vanilline, saccharine, the essence of cummin and salol.

We have also, in our turn, examined the product, whose chemical analysis presents no particular difficulty. The dentifrice does contain essence of mint and saccharine, but it contains neither essence of cummin, carvol, nor salol. On the contrary, some other substance is present, and this substance appears from our experiments to be responsible for the antiseptic qualities of Odol. The manner in which the analysis was conducted was as follows:—

The contents of several flasks of Odol poured into a retort, were submitted, in a water bath, to fractional distillation. By these means we procured alcohol in the receiver. A small quantity of an oleaginous substance of considerable density remained in the retort. This residue was distilled by steam until the essential oil had been removed; that is to say, so long as the water passing into the receptacle presented some minute drops of the odoriferous essence. The condensed water contained essences consisting principally of essence of mint. No evidence of the presence of carvol could be discovered. The matter remaining in the retort after the second operation consisted of a very sweet aqueous solution of saccharine, of sodium, and of oil which deposited itself in the liquid. This oil we were able to separate by means of filtration, with the assistance of a paper that had been previously moistened. Repeated washings left the oil perfectly pure. It was afterwards dried in a water-bath in a porcelain capsule. The oil, when thus dried, is found to be slightly coloured yellow. Its aroma is very faint and suggestive at the same time, of essence of geranium and essence of cedar. It has scarcely any taste; and its reaction was perfectly neutral. It is insoluble in water, but soluble in all proportions in absolute alcohol. Its index of refraction, measured by Abbe's refractometer, is shown to be 1·592. The specific gravity is 1·2.

A sodium lye dissolves the product by decomposing it. For, when the solution is subsequently acidulated, it no longer precipitates oil, but a crystalline substance, which is proved by its reaction to be salicylic acid, whilst at the same time, the presence of very minute quantities of phenol is made evident. It is these reactions which have probably led the analyst above-mentioned to think that salol was present. The following facts, however, prove this opinion to be mistaken. (1) The quantity of phenic acid produced is too minute; and it seems that this phenic acid, which we find, results from a secondary reaction of the salicylic acid. The salicylic acid in turns appears to be the real product of the decomposition; in consequence of which we think that we may conclude the substance to be an anhydrous derivative of salicylic acid. (2) The oil obtained is soluble in all proportions in alcohol, as has been already mentioned. Salol, on the contrary, is with very great difficulty dissolved in cold alcohol. Ten parts of alcohol are required for each part of salol. (3) The oil is neither solidified by cold, nor by the introduction of a crystal of salol.

In order to ascertain whether the traces of essences which the oil contained could prevent its solidification, we made by the way of test, an experiment with salol. An alcoholic solution of salol of 5 per cent., containing a little saccharine and some centesimal portions of the essence of mint, and of the essence of fennel, was submitted to the above-mentioned analysis.

As in the previous experiment, an oily substance remained in the retort. This was separated by filtration from the saccharine, but this oil congealed under the influence of cold, and the addition of a crystal of salol transformed it into a solid crystalline mass, and this in spite of the presence of small quantities of essential oils. According to our analysis, therefore, the dentifrice contains 4 to 5 per cent. oleaginous substance, with a perfectly neutral reaction, saccharine, and some small percentage of essential oils, amongst which it is impossible to recognise the essences of mint and fennel. As for carvol and salol, the dentifrice contains neither.

The dentifrice owes its antiseptic qualities to the oleaginous substance—apart from a minute microbicide power possessed by the essences of mint and fennel. The very efficacious action of the new dentifrice has been proved to us by the following experiments:—

1. First series of experiments. Different portions of six grammes of finely minced meat were mixed with

a	0.05	grammes	of	the oleaginous antiseptic
b	0.1	"	"	"
c	0.2	"	"	"
d	0.5	"	"	"

and after an energetic trituration by means of shaking in a glass, each of these mixtures was placed in a test-tube and covered with 5 cubic centimetres of distilled water. The tubes, placed in a warm chamber heated to the temperature of 30 deg. Centigrade, showed no alteration after having been kept in the warm chamber for several weeks, whilst a control tube containing 6 grammes of minced meat and 5 cubic centimetres of distilled water promptly exhibited all the phenomena of putrefaction.

2. Second series of experiments. Five portions, each consisting of 6 grammes of minced meat, were placed severally in test-tubes containing 5 cubic centimetres of distilled water.

Afterwards were added—

To *a*	0.1	cubic centimetres	of	Odol	dentifrice.
b	0.2	"	"	"	"
c	0.5	"	"	"	"
d	1.0	"	"	"	"
e	2.0	"	"	"	"

Each of the tubes was shaken for a minute so as to make the mixture homogeneous. The tubes were then closed and placed in a warm chamber. Tubes (*a*) and (*b*) as well as a control tube in which no Odol had been placed, became rapidly putrid. The others were still intact at the end of two weeks. We conclude from this that half a cubic centimetre of the Odol dentifrice contains 0·02 to 0·025 grammes of the antiseptic; because, according to our analysis, the dentifrice contains from 4 to 5 per cent. of the antiseptic. It follows that a minute quantity of 0·02 of the antiseptic suffices to preserve six grammes of meat from putrefaction for weeks. Having by these two series of experiments demonstrated the power of the antiseptic to prevent putrefaction, we desired also to demonstrate its effect upon bacteria. For this purpose we selected the micrococcus prodigiosus which developes itself so rapidly, and whose development also, in consequence of its bright red colour, can be so easily perceived by the naked eye. A small portion of nutritive gelatine, containing 1 per cent. of the pure antiseptic, was placed in a tube, and inoculated with the micrococcus. Another tube containing sterilized nutritive gelatine was inoculated in a similar manner. The two tubes were kept at a temperature of 26° Centigrade. At the end of four days the latter tube showed micrococcus prodigiosus largely developed. The odolized tube exhibited no trace of the microbe. The Odol had, therefore, absolutely prevented the development of the bacteria.

W. PARKER.

Appointments.

CIVIL.

ATKINSON, DR. J. R., has been appointed Public Vaccinator to the Third District of the Romford Union.

NORTHCOTT, JOHN FORD, M.B. Lond., L.R.C.P., M.R.C.P., has been appointed by the Secretary of State for India, Special Medical Officer for Plague Duty in the Punjab.

NAVAL.

SURGEON MURRAY P. JONES, R.N., has been appointed to the Plymouth Division, Royal Marines, and SURGEON HAROLD G. T. MAJOR, R.N., to the *Wildfire*.

Births.

BUSTEED.—On August 29th, at Ellesmere, Shropshire, the wife of John Hancock Busteed, L.R.C.P., L.R.C.S., L.S.A. Lond., of a son.

STEPHEN.—On August 30th, the wife of Lionel Stephen, L.R.C.P. Lond., M.R.C.S., of a son.

Marriage.

SUMERLING—GOODWIN.—On September 4th, at St. Edward's Church, Cheddleton, by the Rev. A. H. Boucher, M.A., Bertram J. Sumerling, second son of Mr. A. Sumerling, of Leek, to Miriam, youngest daughter of the late Stephen Goodwin, of Hall's Croft, Leek. At home, 66, St. Edward Street, Leek, October 2nd and 3rd.

Deaths.

COLLINS.—On August 31st, at 9, Oldfield Terrace, Acton Vale, W., George Thomas Collins, M.B. Lond., aged 25.

MICKLEY.—On August 10th, at Freshwell House, Saffron Walden, George Mickley, M.A., M.B., B.C. Cantab.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

ED.—A. P.

Contents.

	PAGE
SALVE!	369–370
VENOUS THROMBOSIS IN HEART DISEASE; Clinical Lecture by Dr. Hale White	371–378
LECTURES FOR SESSIONS 1902–1903	379
THE SCIENCES: Anatomy and the Dissecting Room; Physiology; Biology; Chemistry and Physics; Practical Pharmacy; Materia Medica; Dispensing; Pharmacy, Pharmacology and Therapeutics; Medicine; The Medical Wards; Pathology: Bacteriology; Surgery; The Surgical Wards; Days and Hours of Attendance on Hospital Practice; Dental School	380–391
JOTTINGS ON GENERAL PRACTICE	391–392
PAPERS BY GUY'S MEN	392
PASSIM	393–395
APPOINTMENTS	395
CHAPEL NEWS	395
GUY'S HOSPITAL CLUBS' UNION...	396–400
IN LIGHTER VEIN	400–401
A RARE FORM OF CONTRACTED PELVIS: DIFFICULT CEPHALOTRIPSY: RECOVERY	401–402
CORRESPONDENCE: The Hereafter; The Bermondsey Settlement; Guy's Hospital Physiological Society; Rugby Football; Association Football; Appointm nts	402–403
FROM AN INSTITUTION NURSE'S LETTER	403–404

Calendar of Coming Events.

Sept., 1902.

Sat. 27.—Messrs. Golding-Bird and Dunn's take-in; Drs., F. Hardy and H. O. M. Beadnell; Cl., C. J. Pinching.

Tues. 30.—Exam. for Entrance Scholarship in Dental Mechanics, 9 a.m.

October, 1902.

Wed. 1.—Winter Session begins.
November Appointment List opened.
Distribution of Prizes by the Lord Mayor of London.

Sat. 4.—G.H.A.F.C., I., trial game, home.
II., trial game, home.

Mon. 6.—1.15 p.m., Clinical lecture by Mr. Lucas.

Tues. 7.—First Part Camb. D.P.H. Exam. begins.
First Conjoint Exam. begins.
Preliminary Scientific (L.D.S.) Exam.

Wed. 8.—G.H.A.F.C., I., trial game, home.
II., trial game, home.
November Appointment List closed.

Thur. 9.—Second Conjoint Exam. begins.

Fri. 10.—School Exam. in Anatomy begins.
Test Exam. for L.D.S. Eng.
Test Exam. for First Professional Exam. for L.D.S. Eng.
4 p.m., Meeting of Dental Society.

Sat. 11.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.A.F.C., II., Woodford Albion, away.

Guy's Hospital Gazette.

SEPTEMBER 27, 1902.

Salve!

IT is many years since the GAZETTE first offered a welcome to new comers. Times have changed—many have come and many have gone, but yet the welcome remains as of yore. It matters little why you chose this school for your medical upbringing; chance, perhaps, prejudice, or the advice of a casual acquaintance determined the issue. Be that as it may, the future will see you convinced that your choice was the happiest and that Guy's stands alone in the front rank of hospitals. You may be wrong; very possibly you are wrong, but it will do you no harm to think otherwise, and may result in the very achievement of that which you believed to be already in existence.

Everything is new to you, everything strange, and some things not a little gruesome. But the strangeness will soon depart and that which was horrible remain only as interesting. Your work will soon attract you, and as its attraction grows stronger, so will the tendency to talk in place and out of place correspondingly increase. But the metaphors of the dissecting-room are crude and always vulgar; therefore, restrain the unspoken word, more especially at meal-times.

Life in your first year is very sweet. You have no past to live down, no black page, recurring with maddening frequency at every stage of your career; only a clean white sheet. Therefore must you keep your hands fair and write on it only that which is good. You will be judged afterwards, not by your many successes, but by your single mistakes; not by the things done, but by the things left undone, and the one fault, committed perhaps unwittingly, may mar the whole of your future life.

You will be prone to drop into one of two extremes. Either you will take your life too seriously or too lightly. Strive at the happy medium. The former will lead to mental

ineptitude and the asylum; the latter ends merely in a proficiency at billiards. There are many of you and many medical schools. Also, there are other people who are not medical students. It seems hard to believe at first, but it is a fact none the less. Your life up here will tend to sink you deeper and deeper into a groove, and in this groove you will find others who are working along the same lines with the same thoughts and the same aims. But the world looks down over the edge and laughs.

You will be fortunate if you can get out on the level before you finish at the hospital, for the groove ends abruptly and the return to the world is rude and painful. There you will be taken at the estimation of your fellows and not at your own; not by any means the same thing. Cultivate, if you can, a tolerance for the views of those who do not have the good fortune to be your colleagues; allow some tiny feather-weight to the opinions of the outside world, for the time will come when you will be one of them, and perhaps your example may, by then, have borne fruit.

There is a great change in your life when you first enter into a share in the actual work of the hospital. Perhaps you may be hurt that your honours, your medals, your scholarships have not gone before you. Perhaps you may be pained, but if you are truly a man, as truly a man as you believe, you will be grateful to be taken at your face value, and will start the new life with fresh endeavours.

The man who is slack in his previous work is not held in any less repute by his fellows, for he harms no one but himself. But slackness in the work of the hospital is intolerable, just so far as it increases the labours of others. You may cut a lecture and obtain an ephemeral reputation for devilry. You may allow your part to wither to its end undissected, yet still receive smiles. But leave the wards for week-ends, absent yourself from the surgery in the take-in, and the theatre when your firm is operating and you will find that the most smiling face can mask a biting tongue.

Do not forget that there are people, even as yourself, who are watching you and noting you, pencil in hand. A bad "signing up" dogs your footsteps for ever, trips you at your finals, and assails you when you seek some higher post. Should you be successful in this latter quest you will perhaps remember that you are one of those who are indispensable to the hospital. It will be easy to bear in mind that the hospital could not continue in its present state for one day without its unpaid student staff. But do not concentrate the whole onus, the whole responsibility, upon yourself; for although Guy's must fail if all depart, yet one man can be spared without let or hindrance. And when the time comes for your departure you will find that the regrets are personal simply, and are true or feigned according to your own self; there is no consternation, no despair, for the others are assured that the new man, who wears your old slippers, will soon do as well, and, maybe, better

Sometimes you may, if you are foolish and very young, appraise yourself so highly that the self-estimation hangs round you like a cloud. All the more rude, then, will be the awakening when the world is met, and all the more painful the levelling process which must inevitably follow.

You will meet a number of men, and perhaps you may become of that number, who believe in the cult of exercise. The clubs to them mean much, and they reverence those who hold high positions therein. Everything connected with a hospital competition is honourable; much can be forgiven if it be done for the sake of sport, and much toleration in one who is a sportsman. But you will find also that their ideal sportsman does not fall short of the ideal man of other sects, and as you appreciate this so you will recognise that the athletic world of the hospital is no less important than the reading. In the formation of character you will thus have two alternatives, and, on the whole, the sporting side produces the fairer specimen. But in this as in all else, you must rigidly conserve the principles of universal ethics. Neither here, nor elsewhere, can the individual ride rough-shod over his fellows; there must be a general policy of give and take, and ever before your eyes must stand the noble motto—

"DARE QUAM ACCIPERE."

Venous Thrombosis in Heart Disease.

CLINICAL LECTURE BY Dr. HALE WHITE.
May 28th, 1902.

(For the shorthand notes of this lecture we are indebted to the kindness of the Editor of the CLINICAL JOURNAL).

GENTLEMEN,—To-day I want to tell you chiefly about a rare complication of heart disease of which there is at present an example in the hospital. The woman has been in so long that probably many of you will remember her. She was in No. 14 bed, but is now in No. 17 in Mary ward. Her name is Harriet H——, her age is 24, and she came in so long ago as the 25th of last September. She said her father had had rheumatic fever, and she herself had had it previously. With regard to the present illness, she told us that she had been ailing for seven weeks, when she had a sore throat. You will notice there the importance of sore throat as one of the manifestations of the rheumatic state. Since the sore throat she had had pain first in one joint and then in another. And there you notice also the important factor in rheumatic fever of the pain flying about from joint to joint. At present she complains of the pain in the elbows and knees, and she is breathless on exertion. That, of course, suggests that she has some endocarditis, as she has rheumatic fever. The full report of the case is very long, and I have abstracted it for you. On admission the temperature was 100·4°, and the patient was sweating profusely. You will notice that there is the sweating in connection with rheumatic fever. The history also illustrates the recurrent character of rheumatic fever, because she had had it before. Notice also that it is a family disease, for her father had it. Then, the cardiac impulse was diffuse and heaving, and the cardiac dulness extended a little outside the nipple and a little to the right of the sternum. There was a loud systolic murmur audible at the apex, traceable round to the axilla. You could also hear at the apex a presystolic murmur and an early diastolic murmur. Both these were limited to the apex. Over the aortic area at the second right costal cartilage you could hear a loud to-and-fro murmur indicative of aortic obstruction and aortic regurgitation. So you see the diagnosis was comparatively easy, namely, that the patient was suffering from rheumatic fever; that she had endocarditis of her mitral valve, leading to mitral constriction and regurgitation, and endocarditis of her aortic valve, leading to aortic obstruction and regurgitation. Now, it is unusual in rheumatic fever to get all four valves affected in that way. And you should remember that it is almost always the mitral valve that is affected first, and there is every reason to believe that in this case the affection of the aortic valve took place secondarily to that of the mitral. She was treated in the usual way; that is to say, she was given considerable doses of salicylate of sodium, ten to twenty grains every three hours to begin with, and she was kept absolutely at rest in bed, and put upon a milk diet. Rheumatic fever is such a common disease that you all know the treatment of it. Many of us, in fact I think most doctors, believe that in salicylates we have a genuine specific for rheumatic fever, not perhaps quite on the same footing as mercury, which is a specific for syphilis, for even after cure by salicylates the disease may recur. We know that large doses must be given. Under this treatment the patient improves, the temperature comes down; and we know that it is equally important to keep the patients upon a milk diet, and I am always pointing out to you in the wards that if you want to prevent relapse you must keep up the diet of milk for ten days or a fortnight after the temperature has become normal and the pain gone. On this treatment our patient seemed to be doing well until November 2nd, and then she again illustrated how rheumatic fever is a recurrent disease, for she had another attack of it. It implicated many joints, her temperature went up, and on November 4th we were most anxious about her because she complained of much shortness of breath and cardiac distress. On November 8th there was a loud pleuro-pericardial rub to be heard; that means a rub due to the friction of the lung against the pericardium. In this case it was more dangerous than a pleuritic rub elsewhere, because it suggested that there

might be, or soon would be, pericarditis. You will notice that that is a common complication of rheumatic fever. She was complaining of precordial pain which came and went irregularly, and on November 11th the cardiac dulness, which had lessened since admission, had again increased, and now extended nearly an inch to the right of the sternum and outside the left nipple line. That, again, suggests to you that when people get rheumatic fever they also get myocarditis, or an inflammation of their cardiac muscle, with the result that the heart is particularly prone to dilate; and, as I was saying in the ward only yesterday when speaking upon the same subject, there are probably many hundreds of people going about at the present time with cardiac disease that might not have been as bad as it is if it had been remembered—or if the patients had obeyed the doctor—that it was necessary to keep in bed for a very long time when they had their rheumatic fever. You must, by keeping the patients in bed, rest the heart and prevent the dilatation which will otherwise follow; that is to say, if you get them up. If you believe from the dilatation or from the murmurs that the heart itself is affected in rheumatic fever, it ought to be weeks, often as long as six weeks, before you get the patient up, because by resting him at that stage you may prevent his becoming a case of permanent cardiac disease. On November 13th a well-marked pericardial rub was heard, and that, of course, reminds you how common pericarditis is as a complication of rheumatic fever. The patient, who had been taking digitalis, had been troubled with vomiting, and so two drachms of the infusion of digitalis were given *per rectum* every two hours, and the rectum was washed out daily with a normal saline solution. The cardiac region was at this time very painful; aortic and mitral murmurs could be heard, and also pericardial and pleuro-pericardial rubs. The patient was in considerable distress; the cardiac dulness and the position of the apex remained unaltered, and she was ordered ℥xv. of nepenthe, to be taken three times a day in water, and was put upon small quantities of milk every two hours, and three leeches were applied over the pericardium. We will come back presently to the treatment of pericarditis. On November 20th we noticed systolic retraction of the cardiac apex. This is often correctly interpreted as a sign that the apex of the heart is adherent to the parietal pericardium, so that when the heart contracts in systole the pericardium is dragged in, and it drags in the chest-wall with it. It is a sign of importance, but its importance is much exaggerated, because a pericardium can be adherent without there being a systolic retraction of the apex; and you may see something there like it in people in whom there is no reason to suspect adherent pericardium. But if the patient has had pericarditis and then the apex is retracted during systole, it is very strong evidence that the pericardium has become adherent to the heart. From this date to December 1st the patient's condition may be summed up by saying she was very ill; her temperature was raised usually about two degrees, her pulse was rapid, often weak and irregular; the cardiac apex remained in the same place, and the pericardial rub was sometimes present, sometimes not. The pleuro-pericardial rub was usually audible. The patient was kept absolutely on her back, and she was given enough morphia to keep her gently asleep. Digitalis was given by the mouth or by the rectum. If there was nausea, the drug was given only in small quantities by the mouth, or only by the rectum. She took a little brandy.

And now I come to the features which made this case the subject of a lecture. On December 1st some œdema was noticed on the left shoulder and upper arm, and it was present to a less degree on the left side of the neck. She was very short of breath, and somewhat livid about the face. Oxygen inhalations were used, and we discussed the question whether the œdema was due to thrombosis or to mediastinitis. The patient had been so ill that her back had not been examined for many days; so to-day we rolled her on her side, and extensive signs of pleurisy were found on both sides, with signs of fluid at the base of the left lung. The probable presence of thrombosis made me suspect that the fluid in the chest might be pus, so an exploring needle was inserted into the chest on

the left side, but only clear fluid was withdrawn. The fluid was submitted to Mr. Pakes, who reported it was sterile. Towards evening the patient became very weak, and it was necessary to inject strychnine subcutaneously. On December 12th the œdema on the neck and arm was much more marked, especially on the left side, and it extended down to the fingers and also a little over the upper three intercostal spaces on the front of the chest. On pressing over the right shoulder and the right clavicle and the side of the neck, there was considerable tenderness; the patient did also complain a little of pain in the neck. The face was cyanosed. From this time the œdema gradually got less. In a few days it was possible to feel both external jugular veins; they were hard, as thrombosed veins are. On December 20th and 23rd she had two severe attacks of dyspnœa, with lividity, and on each occasion that was relieved by oxygen and by venesection. From this time there was continuous but very slow improvement in all respects. She often had severe dyspnœa on the slightest exertion, and that was not surprising when we remember that she had obstruction and regurgitation at both aortic and mitral valves, and also an adherent pericardium.

Now I will refer to my second case, and then I will tell you about the facts of the cases. The next patient is a man æt. 26, whom I saw on April 6th of this year, with Dr. Daunt. The patient had been previously under his doctor's care eight weeks ago for influenza, and before that was well he had insisted on going to Devonshire strongly against his doctor's advice, when he was too weak to undertake the journey. His doctor in London has been told that while there he had pneumonia and was very ill. He came home a month ago, when he was still far from well; he insisted on going to his work, so there was no proper opportunity of examining him. For two or three weeks he probably has had dulness at the base of both lungs. On April 5th he began to get livid about the head, face and neck. When I saw him on April 6th the head, neck, and to a less degree the upper two inches of the front of the thorax, the arms and the finger nails were all livid. The rest of the body was of a healthy colour. The veins on the chest were marked, and also those on the neck. Both external jugulars felt hard. The livid part was somewhat œdematous, that is to say, both arms, the face, and the neck. The pulse was rapid and weak: both pulses were equally weak. The heart appeared a little dilated, the apex being outside the nipple line. The heart-sounds were very feeble, and I thought I detected a faint systolic murmur over about the position of the middle of the heart. Still I was not sure about it. I thought there was some little dulness in the second right intercostal space, and that suggested to me the possibility of an aneurysm, but I soon dismissed it from my mind. The patient was very young for such a condition; and aneurysms by pressing upon veins do not, as a rule, produce lividity. As a rule, in order to produce lividity it is necessary to block the inside of the vein. Therefore, if the case is one of either aneurysm or growth, and the veins are much dilated, it is very strong evidence that of the two the diagnosis of growth is correct, because the growth will grow into the interior of the vein and thrombose it, while aneurysms will just stretch it. Now, to go back to this patient; the air entry into both lungs was equal. The history was very imperfect and difficult to get; but bearing in mind that he had had pneumonia, and that the bases of both lungs were very dull and he was very livid, I thought he possibly might have an empyema, for this makes people very livid. I did not think it likely, but to be sure I put the needle into both sides of the chest, but in neither case was any fluid withdrawn. On the whole, therefore, the diagnosis made was that it was most likely the patient suffered from influenza, afterwards with pneumonia, and had some thrombosis of the veins opening into the superior vena cava. He was so livid that we wished to venesect him, but he and his friends objected, and therefore three leeches were applied over each side of the neck, and the leech-bites were fomented so that the patient bled considerably. On April 8th I saw him again, and then I found that he was much better. The previous œdema about the arms, the neck, and upper part of the chest was less

the veins on the thorax were still well marked, and there was a little ring of dilated veins about the lower part of the chest. There was no doubt now about the systolic murmur; it was loud and audible at the apex of the heart, and was conducted to the axilla. There was a well-marked cardiac impulse in the sixth space, half an inch outside the nipple line. I thought the probable reason that the previous cardiac impulse had been so diffuse and the murmur had not been heard was this: that owing to the great venous distension in the neck the right heart was dilated, and the whole heart could not contract properly, and so there was not enough force in it to make a murmur.

So in both these cases we have patients who had lividity and œdema of the arms and head and neck. When people have lividity and œdema of the arms and head and neck it is quite clear that there must be some block in the flow of blood back through the superior vena cava. What we have to do to-day is to think what that might be.

As I mentioned just now, both growth and aneurysm should come into your minds as possibilites. But both these patients were suffering from heart disease, and we wanted their œdema and lividity to fit in with their heart disease. Further, there was no evidence in either patient of growth or aneurysm. Both the patients were young for such conditions, and we were able, by going over the cases, to quickly put these out of court. Although influenza might apply to one patient it certainly would not to the other. The two other things which were suggested at the bedside were that there was some mediastinitis, or that there was some thrombosis of the veins at the root of the neck. Fortunately, it so chanced that in the course of medical reading, while the woman was in the hospital, I happened to read an account of a case of heart disease with thrombosis of the veins of the upper part of the body, recorded by Dr. Ford, of Montreal, in a Canadian medical journal. That gave me the reference to some cases which have been recorded by Professor Welch, who read his paper before the Association of American Physicians. And our two cases fit in so well with his description of that rare complication of heart disease, namely, thrombosis of big veins opening into the superior vena cava, that I thought we might profitably, this afternoon, compare our two cases with the description he gives of that rare condition. You know thrombosis, as I have often pointed out to you in the wards, is a common disease. The two acute diseases which frequently lead to it are typhoid fever and influenza; and the two chronic diseases which lead to thrombosis are tubercle and cancer. Now, I mention that because it is very important you should remember that so far from thrombosis of the systemic vessels being very common in heart disease because of the difficulty of circulation, you see that it is not so, it is a very rare complication, and I have not myself seen it before this winter. Diseases in which there is probably no particular difficulty of circulation, namely, typhoid fever, influenza, phthisis and cancer, are those diseases in which, over every other, thrombosis is frequent. That reminds us of what one is always pointing out, that the clotting of blood inside the body is not due to any single factor as far as we at present know. At any rate, that single factor is not the retardation of the circulation. When I say that thrombosis is very rare in heart disease, please remember that I am strictly confining my remarks to the general systemic veins. You know thrombosis is very common during heart disease in the branches of the pulmonary artery, in association with the ordinary pulmonary apoplexies which you so frequently see in the lung. And then, also, thrombosis in the arteries in heart disease is not uncommon in those cases where there is atheromatous change of the aortic valves. You get atheromatous change in the arteries of the body, and thrombosis in the atheromatous vessels.

Now there comes this fundamental fact about this rare condition. The thrombosis of the systemic veins that occurs in heart disease occurs nearly always, as our two cases illustrated, in veins of the upper extremities and the head and neck. It is difficult to know the exact proportion, because the cases are so few, but it is something like fifty to one in favour of the veins of the

arms and head and neck rather than the other veins in the body. That is a remarkable thing, and shows that it is a special complication of heart disease, because you will remember that in influenza and typhoid fever and tubercle and cancer—the other four diseases that frequently lead to thrombosis—the thrombosis is nearly always in the veins of the lower extremities. So in nearly all common cases of venous thrombosis it is the veins of the lower extremities which are affected, but in heart disease, for some reason which we do not know, it is the veins of the upper extremities and of the head and neck. Now, of twenty-two cases in which Professor Welch was able to get the age and sex of the patients, he found seventeen were females and five males. That is probably, if anything, a higher proportion of females as against males than the fact I will point out to you directly, namely, that this complication of heart disease is much more frequently associated with mitral than with aortic trouble, should warrant. With regard to age, our cases illustrated the point that this form of thrombosis occurs in young people between fifteen and thirty years of age. The woman was twenty-four and the man twenty-six. In every case but one of Dr. Welch's series there was mitral disease, organic disease of the mitral valve. Both our patients confirm that, for they both had organic disease of the mitral valves. And sometimes the aortic valves are affected too; as a matter of fact, ten times out of the twenty-two. Our cases bear that out also, because one of our two had the aortic valves affected also. There was in Professor Welch's series always mitral regurgitation, and there were often symptoms of mitral obstruction too. And that harmonises with our experience, for both our patients had mitral regurgitation, and one of our patients had mitral obstruction as well. In all the recorded cases the valvular disease was chronic, and in one quarter of them acute conditions supervened upon the chronic. That likewise harmonises with our experience, because both our cases were clearly instances of chronic heart disease, and in the woman it is probable that some acute trouble supervened upon it. In one quarter of Professor Welch's cases there was adherent pericardium. Our cases remind us of that fact, because the woman had an adherent pericardium. So we may sum up by saying that this form of thrombosis is particularly found in young adults suffering from mitral disease, and that to some extent explains that it is much commoner in women than in men, because mitral disease is commoner in women. Another point is that it appears during the period of extreme failure of the heart. Many of you here have seen our female patient, and you will admit that if anyone was in a state of extreme failure of heart that woman was. And that was true also of the man. From this it follows that there is often tricuspid regurgitation and other symptoms of serious heart disease.

Now it is important you should know the locality of the thrombi, and I will put up the figures in regard to that on the blackboard. Out of twenty-four cases the thrombosis was on the left side in twenty-two; and of these twenty-two fifteen were unilateral and seven bilateral; that refers to unilateral as regards the arm and the same side of the neck. It was right-sided only in two. So you see there is the curious clinical fact which both our cases illustrated, that the left side is very much more often affected than the right. But our cases do not quite accord with the above distribution, because in both our cases the thrombosis was bilateral, and it is more frequent to get it unilateral than bilateral. The rarest thing is to get the veins on the right side affected, and not the left. In seven of the twenty-two cases it was limited to the arm, in one case it was limited to the neck, and in sixteen it was in both. That corresponds exactly with our experience, because in both our cases both arm and neck were involved. Inasmuch as the thrombosis is frequently bilateral, you get both internal jugulars, both the subclavians, and both innominate veins affected, and you will remember that in our cases we felt both external jugulars to be involved. The brachial and axillary veins are also affected, and that is about the order in which the veins are found to be thrombosed. In very severe cases even the superior vena cava itself is thrombosed. Post-mortem experience shows that the starting-point of the clot

is at the lower part of some vein, for instance, the internal jugular, at the lower part of the innominate veins where they join, or at the lower part of the subclavian or external jugular, as the case may be. Also, post-mortem experience seems to show that as a rule the walls of the veins themselves are not diseased, as well as the fact that very often the lymphatic glands in the neighbourhood of the veins are actually inflamed.

I have pointed out to you that this condition exists, and I do not think the symptoms need detain us long. There is, of course, pain. The woman complained of pain over the affected area. All thrombosed veins are tender. There are also lividity and œdema over the affected area. Then, when the œdema has gone down and you come to feel the veins, you will find that they are like hard thrombosed cords. There is only one point about the œdema to which it is necessary to draw your attention particularly, and it is this, that the œdema in any severe case usually extends about two inches on to the thoracic wall. So we might sum up the symptoms of this disease rapidly as a quickly appearing lividity and œdema affecting the face, neck, and upper extremities, and extending two inches on to the thoracic wall; that the patient complains of pain and tenderness; and that the course of the veins can be felt. Those are really all the symptoms except that there is also often distension of the superficial veins. You might say that thrombi in other parts of the body usually cause symptoms, such as rigor and fever, but any general symptoms due to thrombosis in heart disease are usually over-shadowed by the serious illness of the patient due to the heart disease. Bacteriological examination has only been made in three fatal cases. In two it was negative, and in the remaining case *Streptococcus pyogenes* was found in the clot. As you would expect, it is a very serious symptom, and out of twenty-four cases twenty-two died. The wonder is that the woman upstairs did not die; indeed, neither she nor the man are yet out of the wood. So we cannot say with regard to our two cases whether there will be a fatal or a successful termination. I think the woman will recover, but the man is still very ill.

I cannot do much, I am afraid, in explaining this peculiar localisation of thrombosis to you. It is quite different to the localisation of venous thrombosis in other diseases, but it has been suggested that the greater length and obliquity of the left innominate vein accounts for it occurring largely on the left side. It has been suggested that the position of the valves in the left internal jugular, external jugular and subclavian veins would favour clotting. Whether this is so or not I do not know. It has been suggested that in these cases the dilated left auricle will press upon the left innominate vein, and that some of the patients, like the woman, may have considerable pleuritic effusion, and that the fluid will press upon the innominate vein. But, after all, these are only suggestions, and I give them to you for what they are worth. Professor Welch himself is inclined to think that thrombosis generally may be related to a kind of whirling movement of the blood. He says he thinks that in these cases you are very likely to get such whirling movement. He suggests that the cervical fascia holding the veins open, that the disposition of the valves, that the bulbous end of the internal jugular, that the meeting of currents of blood at different angles, that the backward flow of blood because of the regurgitation through the tricuspid, will all help it. But, after all, as I say, these are merely suggestions. He thinks the determining factor is really the presence of bacteria. That is all I have to tell you about this rare complication, and I brought the cases to your attention to-day because venous thrombosis is a rare complication of heart disease which has not yet been often described, and therefore this discussion may be useful.

The other point I wanted to refer to is the occurrence of mediastinitis. This is very rare, that I am sure of; the word means inflammation of the areolar tissue of the mediastinum. In ten out of eleven cases the inflammation is suppurative, and is frequently due to a blow or to caseous glands suppurating. In neither of our cases was there any evidence of pus. Those cases form a category by themselves. We have now left a rare mediastinitis which is not suppurative, and that is what is com-

monly called chronic mediastinitis. That is an excessively rare condition; and it is only, I think, one or two years ago that Dr. Frederick Taylor gave an address on the subject. I have nothing more to tell you in addition to that. Chronic mediastinitis is very frequently associated with pleurisy and with adherent pericardium—if you can call anything frequent in such a rare condition,—therefore adhesions of the pleura and adhesions of the pericardium quite overshadow the inflammation of the cellular tissue of the mediastinum, and make the diagnosis of mediastinitis at the bedside very doubtful. One point which does help you with the diagnosis is, that these rare cases very frequently have some chronic peritonitis as well. So we might sum up the condition of chronic mediastinitis in what I have told you. We may say it is a very rare condition indeed, associated particularly with adherent pleura and adherent pericardium and with chronic peritonitis, and that during life so many of the severe symptoms are due to adhesions of the pericardium and adhesions of pleura, and possibly also to chronic peritonitis, that it is almost impossible to disentangle the symptoms so as to assign correctly which symptoms are due to mediastinitis and which are due to the other conditions. But we did suggest at the bedside that the woman might have this condition, because you see it would account for an increased pressure on the superior vena cava and its branches, and she had an adherent pericardium and adherent pleura, and we knew that mediastinitis was associated with these conditions. I need hardly tell you that the presence of the thrombosed veins at once put this out of court, and at the best it was not a very good suggestion, for the difficulty of it was this, that her œdema and her lividity were confined to the upper part of the body, so we should have to suppose that her mediastinitis, while it did still hamper considerably the return through the superior vena cava, was not troubling her much as regards the return to the inferior vena cava. And there is so little vena cava in the thorax that that might have been so. But as a rule people with mediastinitis suffer from general œdema and lividity.

And the last point I wanted to draw your attention to is, as to what you are to do with a patient who has acute pericarditis. The woman's case illustrated the points so admirably that I cannot resist the temptation to lay them before you. By attending to these points properly you not only save the patient's life, but you may determine whether she shall be a perpetual chronic invalid, or whether she shall be in a position of fairly good health. The adhesion of pericardium to the heart does not appear to matter very much, provided that the adhesion takes place when the heart is of normal size; but if the adhesion takes place when the heart is dilated, the adhesions will always hold the heart stretched out; and then no amount of treatment can do the patient much good. So your object is to treat the patient in such a way as to prevent the heart getting dilated, but to obtain adhesions upon the heart in its normal size, and not when it is a great flabby organ. The reason why the heart dilates so readily is that there was never a pericarditis without some co-existing myocarditis, often in considerable degree, and also the fact that the pericardium itself becomes soft and sodden, so that it easily gives way. Now that I have told you that, you all know what to do. Your object is clearly to prevent in every possible way the heart from dilating; and the best way to do that is to give it very little work to do so as not to increase the pressure within. So first of all keep the patient absolutely at rest in bed. We did not sit our woman patient up for many days together to examine her back, and I am sure we did right. What could we do if she had a pleuritic rub? We could have done nothing which would have compensated for the harm that might have followed in the shape of dyspnœa and cardiac dilatation. So be sure to keep your patient absolutely quietly at rest in bed.

We will take the question of diet next. What have we to aim at? You want to prevent dyspepsia, because such a patient, on account of the condition of the mucous membrane of her stomach, is very likely to have dyspepsia. There are the dilated veins in the stomach, and there is a coating of mucus, and in view of

these facts you must feed your patient accordingly. What could be worse than for such a woman as our patient to get flatulence and dyspepsia? The flatulence pushes up the heart and makes its action irregular. Therefore, at all costs, prevent flatulent dyspepsia. We kept her upon small quantities of milk and easily digestible food, giving her only very small quantities at a time and at frequent intervals, because we did not want to distend the stomach. And for the same reason, because we did not want her to be dyspeptic, we kept the bowels regularly acting, and rather than have vomiting and flatulence you must feed *per rectum*.

The key-note of the next step in the treatment is again to rest the heart as much as possible. During sleep our heart's action is ten beats slower per minute than when we are awake. You will see what an enormous amount of rest is obtained for it if you multiply ten beats per minute by sixty, and then that by the number of hours sleep. So we kept our patient comfortable and quietly drowsy. As a rule she did not notice us very much when we came into the ward; she slept very well at night, and she slept in the afternoon, because we gave her nepenthe. If it will not be absorbed by the stomach, you must give opium by subcutaneous injection; it is most valuable in the treatment of pericarditis.

The next point is one in regard to which I think you will find people are often, I believe, in error, and that is in regard to the administration of digitalis. They say you should not give a patient with severe pericarditis digitalis, because it increases the amount of work which the heart has to do. That may be so, but you slow a heart which is usually rapid, and you slow it by prolonging the diastole. It is an ideal drug. A heart is perhaps beating at 120 per minute, and you bring its rate down to 80. In that case, therefore, you slow its beats 40 per minute by prolonging the diastole, and this rests the heart. Just look at the increased length of diastole every minute. Another thing is, digitalis tones up the heart generally and contracts it, thereby helping us to get adhesions on a contracted instead of on a dilated organ. So I am sure I have often seen good effects at the bedside by the prolonged rest which digitalis gives to the heart, and by the fact that it tones it up and keeps it contracted. The advantages of digitalis in pericarditis greatly outweigh the disadvantages. I have not infrequently seen patients who were very ill with pericarditis immensely improved directly digitalis was given. But it is a drug which frequently produces vomiting; therefore, the moment there is any suspicion of vomiting, you must give the drug *per rectum*. Digitalis was given *per rectum* in our patient.

Again, I do think that sometimes—though I cannot explain why—you do the patients good by putting some leeches over the heart region; at any rate, there is no doubt that the leeches relieve the pain. I think those are the chief points to which I wanted to draw your attention in treating pericarditis.

Appointments.

CIVIL.

ATKINSON, T. REUELL, M.D. Durh., M.R.C.S. Eng., has been appointed Public Vaccinator for the Third District of the Romford Union.

JONES, R. ORFORD, L.R.C.P., L.R.C.S., L.F.P.S., has been appointed Poor Law Medical Officer and Public Vaccinator for the Seventh District of the Kingsbridge Union (South Devon).

KIRKMAN, ALBERT H., L.R.C.P. Eng., M.R.C.S., has been appointed Railway Medical Officer at De Aar, Cape Colony.

POOLE, THOMAS BRICE, M.D., B.S., M.R.C.S., L.R.C.P., has been appointed Hon. Medical Officer to the South Wimbledon and Merton Cottage Hospital.

SHEEN, WILLIAM, M.S., M.D. Lond., F.R.C.S. Eng., has been appointed Honorary Surgeon to the *Hamadryad*, Seamen's Hospital, Cardiff.

THOMAS, T. P., B.A. Cantab., L.R.C.P. Eng., M.R.C.S., has been appointed Honorary Surgeon to the Aberystwith Infirmary and Cardiganshire General Hospital.

MILITARY.

Captain F. S. BRERETON, R.A.M.C., has been detailed for service in India.

Lieutenant H. D. PEILE, I.M.S., is promoted to be Captain.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Lectures* for Sessions 1902–1903.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Lane and Mr. Dunn	9	—	Tu	W	Th	Fri	—
Microscopical Pathology (3rd) ...	Mr. G. B. Smith and Dr. Eyre	9	—	Tu	—	—	Fri	—
Pathological Classes (3rd & 4th)	Dr. Fawcett and Mr. Steward	9.15	—	—	W	Th	—	Sat
Bacteriology (Oct. & Nov.) (4th)	Dr. Eyre	4	M	Tu	—	—	Fri	—
Practical Obstetrics (3rd & 4th)	Mr. Targett (Oct.)	—	—	Tu	—	—	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Pembrey, Dr. Beddard & Dr. Spriggs	11	—	—	—	—	Fri	Sat
Biology and Botany (pre. sci.)...	Dr. Stevens	2	—	—	W	—	Fri	—
Chemistry (1st and pre. sci.) ...	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ryffel and Mr. Ball ...	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Pembrey	11	M	—	W	—	—	—
Practical Medicine (3rd) ...	Dr. French and Dr. Turner	12.30	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Ball ...	12	M	—	—	—	Fri (2)	—
Chemical Physics (1st)	Professor Reinold	2	—	—	—	—	Fri	—
Practical Surgery (3rd)	Mr. Simpson	12	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey (Oct.-Dec.)	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th) ...	The Physicians	1	—	—	—	—	—	Sat
Surgery (3rd)	Mr. Lucas and Mr. Golding-Bird ...	9·30	M	—	W	Th	—	—
Clinical Surgery (3rd & 4th) ...	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st) ...	Dr. Stevens and Mr. Swan	2	—	—	W	—	Fri	—
Mental Physiology (Oct. & Nov.) (3rd & 4th)	Dr. Savage and Dr. Hyslop	2	M	Tu	—	Th	—	—
Morbid Anatomy (3rd & 4th) ...	Dr. Fawcett and Dr. Bryant	2	M	Tu	W	Th	Fri	Sat
Medicine (3rd)	Dr. Taylor and Dr. Hale White ...	4	M	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Higgens	3	—	—	W	—	—	—
Public Health (Jan.) (4th) ...	Dr. Sykes	4	M	—	—	—	Fri	—
		—						
Dental Surgery and Pathology...	Mr. Newland-Pedley	4	—	—	—	Th	—	—
Metallurgy	Dr. Wade	4	M	—	—	—	—	—
Practical Dental Metallurgy ...	Mr. Hopson (Jan.)	3.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology...	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Wynne Rouw (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics ...	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.					
Medical Jurisprudence (3rd & 4th)	Dr. Stevenson	9.45	—	—	W	—	Fri	—
Midwifery (3rd)	Dr. Horrocks and Mr. Targett	9	—	Tu	W	Th	—	—
Diseases of Women	Dr. Horrocks and Mr. Targett	9	—	—	—	—	Fri	—
Pathology (3rd)	Dr. Pitt	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Savage	9.30	—	Tu	—	—	—	—
Bacteriology (May & June) (4th)	Dr. Eyre	9.30	M	Tu	—	—	Fri	—
Practical Obstetrics (3rd) ...	Mr. Targett	—	—	Tu	—	—	—	—
Biology and Botany (pre. sci.) ...	Dr. Stevens	2	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Pembrey	11	M	—	W	—	—	Sat
Histology (1st)	Dr. Pembrey, Dr. Beddard and Dr. Spriggs	9	M	—	W	—	—	Sat
Practical Medicine (3rd) ...	Dr. French and Dr. Turner	12.30	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Ball ...	12	M	—	—	—	Fri (2)	—
Clinical Medicine (3rd & 4th) ...	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th) ...	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Morbid Anatomy (3rd & 4th) ...	Dr. Bryant and Dr. Fawcett	2	M	Tu	W	Th	Fri	Sat
Materia Medica (2nd)	Dr. Perry	4	M	—	W(3)	—	Fri	—
		—						
Operative Dental Surgery ...	Mr. Badcock	9	—	—	—	Th	—	—
Chemistry	Dr. Wade	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Dr. Wade, Mr. Ryffel, and Mr. Ball ...	9	—	Tu	—	Th	—	—

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

ANATOMY AND THE DISSECTING ROOM.

How to begin Work.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully indifferent how to set about it. The very names of the subjects we have been told to learn convey no meaning, and the school buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be, that is briefly; whether they are going in for the Preliminary Scientific Examination of the London University or not. Information on these matters is readily obtained at the medical school office, and any student who is not clear in his mind as to the examination he has to prepare for, should read carefully page 72 in the green book.

After the first few days men soon become familiar with the work, and learn from one another. But at first they have made no acquaintances, and all around them are strangers alike.

Under the Five Years' Regulations of the Conjoint Board, the first object of the student (entering, for instance, in October, 1902) is to pass the examinations in Chemistry and Biology, as failure to complete these by the following March (*i.e.*, 1903) must postpone the date at which the Second Conjoint should be passed (*i.e.*, April, 1904), *vide* par. 6, p. 394, so that students are advised, unless they have passed either one or both of the above subjects before entering the hospital, or are unusually well versed in the subjects for these examinations, to postpone dissections until one or both (Chemistry and Biology) have been completed.

What follows refers, therefore, only to those who intend to undertake their dissections at once.

Wednesday, October 1st.—There is no actual work done on this day, but each student who is ready to dissect (*vide supra*) should pay his fee, *vide* par. 2, p. 394, for anatomical material in the medical school office, and take the receipt across to the dissecting-room and present it to the demonstrators. He should then study the red book—which contains the rules of the dissecting-room—and purchase the necessary instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the green book will show them at a glance, and serve as a very efficient guide.

Thursday, October 2nd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture by Mr. Lane in the anatomical theatre, and at 12 o'clock a demonstration is given by the Senior Demonstrator in the small theatre attached to the dissecting-room, both of which every new student is expected to attend.

To find a "Part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, scissors, hooks, needle and blowpipe. Price 15s. to 20s., at Messrs. Down Bros., of St. Thomas's Street; or at Messrs. Hills & Co., of Newcomen Street; also from Hancock, the dissecting-room attendent.

b. Books. These are obtainable at Grattan's in the Borough, next door to the post-office. It is advisable to obtain either *Ellis's Demonstrations of Anatomy* (9s. 6d.), or, better, the more expensive *Cunningham's Practical Anatomy* (2 vols. 9s. 6d. each) for use in the dissecting-room, which show how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Morris or Quain. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the Medical School Office. During the day hats and coats are kept at a special cloak-room near the dissecting-room.

d. A disarticulated skull and a half skeleton. (*See below*).

With regard to all the necessary articles mentioned above in *a b* and *d*, it is well to point out to the new students that many men who have just completed their anatomical studies may wish to dispose of some of the above articles second-hand, and new students may obtain information about, and details of such things

to be bought, from the librarian, Hancock, or the commissionaire, with whom such things are usually lodged. Before completing any such purchase it is always best to make sure that the books are of the last edition published and that the instruments are reliable, points on which any of the demonstrators will gladly give advice.

How to Dissect.

The instructions given on this point in the text-books are by no means clear to one who has never done any dissecting in his life, and who does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical descriptions depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful act of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the *different structures that he reads about in his books.* It is most decidedly not the object of dissection to lay bare the bone in the middle of the "part" in the shortest possible time. That is butchery, not dissection. The following advice, then, may be given: —

1. Take your book by which you intend to dissect (Ellis or Cunningham) and read over the pages giving directions for the skin incisions to be made in that particular part you are about to dissect.

2. Cut through the skin along the lines given in the books.

3. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

4. Take away the fat carefully without damaging the dense white layer which covers the muscles.

5. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

6. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the wax model museum preparations. *Most important of all, never remove any structure until you have obtained a good mental picture of it, and have also read in your book the description of it, and have satisfied yourself you know it.*

7. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

8. Cover the "part" up with a cloth before leaving it for the night.

The red book containing the rules of the dissecting-room will be found to contain a lot of useful information, which we give in full below, and should be read with care, and then kept always at hand.

Osteology.

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy it must be learned practically—by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half-sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the second Conjoint examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is as well to have the guidance of a fellow student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary now that the Elementary Anatomy examination has been done away with at the College, to caution men against neglecting the subject during their first year. They will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the hospital "Bone" examination at the end of the first winter session, if they neglect the bones in their first month's work.

Rules of the Dissecting Room.

1. All first and second year's students, and all those senior to the second year, who have not passed the Second Conjoint Examination, are expected to attend in the dissecting-room on the first day of the Winter Session, between the hours of 1 and 4 p.m., or on the second day between the hours of 10 a.m. and 12 noon. Each student must bring with him a voucher indicating that he has paid the special fee for material, which voucher must be handed to the demonstrator in order

that the student's name may be enrolled in the appropriate class list.

2. The fee for material (which should be paid in the Medical School Office on or before the first day of the Winter Session, between the hours of 10 a.m. and 1 p.m.) is—

For each academic year:—

First Year's Students	25/-
Second Year's Students	
Students Senior to the Second Year but not yet through the Second Conjoint Examination	

For each three months:—

Students who have passed the Second Conjoint Examination and are preparing for any later examination	10/6
Students for the L.D.S. Examination only	

3. The senior demonstrator (Mr. Fagge) will meet the first year's students on the second day of the Session at 12 noon, and give them a demonstration to initiate them into the work of the dissecting-room. Immediately after this demonstration parts will be allotted to students.

4. On the following day the bone classes, which are held by Mr. Rowlands and Mr. Swan, begin. Every student is advised to purchase a half skeleton and to bring to the class the bone or bones which will form the subject of the demonstration. Regular attendance at these classes is compulsory until a student has passed in Elementary Anatomy. A student attending the class that is studying (A), (B), or (C), in Rule 8, will be allotted a part corresponding with the work of the class.

5. The senior demonstrator will meet the second year's students on the third day of the Session. The Second Conjoint Class demonstrations given by Mr. Rowlands and Mr. Swan begin early in the following week.

6. No student shall be enrolled in the Second Conjoint list or allowed to begin dissecting as a second year's student until he has passed in Elementary Anatomy and in Biology and Chemistry at the First Conjoint Examination.

7. The notice-boards in the dissecting-room should be examined daily throughout the Session. Here will be found class lists, notices of allotment of parts, announcements of vacancies for prosectors, arrangements for examinations, etc., and notices of alterations in standing arrangements. Every student's name should appear in one of these class lists, and any student failing to find his name should at once inform one of the demonstrators.

8. A written examination is held just before the Christmas vacation. Every first year's student, whether medical or dental, is required to attend and to answer the questions on one of the following groups:—

(A) The bones and ligaments of the head, and the bones, ligaments and muscles of the upper extremity; or

(B) The bones and ligaments of the spinal column and thorax, and pelvis, and the bones, ligaments, and muscles of the lower extremity.

Every second year's student is required to attend and to answer questions on—

The muscles, tendons, bones and ligaments of the whole body; and one of the following groups—

(α) The entire anatomy of the upper extremity and of the head and neck, including the brain and spinal cord; or

(β) The entire anatomy of the lower extremity and of the abdomen, pelvis and thorax; or

(γ) (*if he is taking the L.D.S. only*) The entire anatomy of the head and neck, excluding the brain.

9. The dissection of all parts allotted in October and November must be completed before Christmas, and on the second day after the recess new parts will be allotted, priority being given as far as possible to those students who showed themselves most painstaking in their previous work. A first year's student who, before Christmas, studied sub-division (A) in Rule 8, will now study sub-division (B); but in addition every student should, in this his second part try to master as much as possible of the vessels, nerves, etc.

10. A school examination in Elementary Anatomy on the bones, ligaments, and muscles of the whole body, is held four times a year, in March, July, October, and December; this must be passed by every one before he is allowed to commence the recognised period as a "second year's" student.

11. The senior demonstrator holds (i.) classes throughout the Winter and Summer Sessions for students preparing for the First F.R.C.S. and M.B. Examinations of the various universities in general advanced Anatomy and in Embryology. (ii.) Revision Classes before each of these Examinations. (iii.) Revision Classes for students who, though they have completed their second year, have not yet passed the Second Conjoint Examination.

12. Every student is advised to carry with him when in the dissecting-room and demonstration theatre a pocket note-book and a set of coloured chalks.

13. Every week the dissections are examined systematically by the demonstrators, and marks are allotted. The record thus kept of each student's diligence in the dissecting-room is taken into account in subsequently recommending to appointments in the wards.

14. A test examination is held about three weeks before each Second Conjoint Examination. Attendance at this examination is compulsory on all those who wish to present themselves for the Conjoint Examination.

15. Particulars of the examinations for the Michael Harris, Arthur Durham, and Hilton prizes, and for the prizes for General Proficiency will be found in the Prospectus of the Medical School, which may be obtained in the medical school office.

16. About twelve prosectors to the lecturers on Anatomy are appointed annually (and from time to time a prosector to the Royal College of Surgeons of England) from among those students who have shown themselves most diligent in the dissecting-room. Notices inviting

applications for these appointments are posted in the dissecting-room.

17. The metal ticket attached to each part must on no account be allowed to come off nor to be covered up by the bandage that each student should apply to his part (if a limb); neglect of this rule renders the part liable to be forfeited. Apron and sleeves (2s. 6d.), bandages, cloths, air-pump, ointment, carbolic lotion, etc., can be obtained from the dissecting-room porter.

18. No muscle, tendon, nerve, artery, or large vein, should be cut through, if by hooking it aside it is possible to reach and clean the parts lying on its deep surface.

19. No limb must be removed from the trunk except by one of the demonstrators or assistant demonstrators, nor in any circumstances must any part of a subject be removed from the dissecting-room.

20. Except when the student responsible for a part is actually at work upon it, each part must rest constantly on the table of the subject to which it belongs. Neglect of this rule renders the part liable to be forfeited. When a student considers he has finished the part, he must report the fact to one of the demonstrators.

21. The subject is divided into five parts on each side:—

1. The Head and Neck and Spinal Column.
2. Upper Extremity and Muscles connecting it with the Trunk.
3. Abdomen, with the Perinæum and interior of the Pelvis.
4. Lower Extremity.
5. The Thorax, the dissection of which is not to commence until the fourteenth working day.

22. Students are not permitted to exchange or dispose of their parts, either before or after the commencement of dissection.

23. Any part, the dissection of which has not been begun within twenty-four hours from the time when the body is placed in the dissecting-room, is liable to forfeiture. If a student is unable to continue the dissection of the part which he has already begun, he must give notice *in writing* to one of the demonstrators, who will make arrangements for its disposal. The demonstrators will also dispose of any part, the dissection of which has been discontinued without their sanction for more than two working days.

24. The subject when brought in will be placed in the supine position, and will so remain during nine working days. On the tenth day a majority of the students engaged upon it, and on the fourteenth day any one of them, may have it turned into the prone position. Five days later it may, if the majority so desire, be turned back again; and after six days in the prone position any one of the dissectors may have it turned back. The time for the dissection of the perinæum is before 11 a.m. on the first ten days, and neither for this purpose nor for any other must the subject be turned out of the position indicated in this rule,

25. The dissecting-room is open from 9 a.m. till 4.30 p.m., except on Saturdays, when it is closed at 2 p.m.

26. On applying at the Medical Office a locker may be obtained for a deposit of Five Shillings (which will be returned when the key is given up, provided that the locker is uninjured).

DENTAL STUDENTS.

A dental student, on entry, must pay the fee (10s. 6d.) for material at the medical school office, on October 1st, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Fagge to first year's students, on Thursday, October 2nd, at 12 noon.

Special classes on the bones, ligaments and muscles of the head and neck are held for first year's dental students by Mr. Rowlands, in the dissecting-room theatre on Wednesday, at 3.30 p.m. throughout the winter session (beginning on October 8th).

During their first winter session dental students entering in October are expected to dissect the head and neck and to study the bones and muscles of the head with the temporo-maxillary and cervical articulations upon which they are examined at the end of the session in which they dissect the part. In addition, they should become acquainted with the main vessels, nerves, and special structures of these regions.

For those dental students entering in May a similar set of classes is held by Mr. Rowlands from May to July, on Tuesdays, at 1 p.m. These students are also expected to finish their first part (head and neck) during the summer session and are examined on it in July. Failure to satisfy the examiner entails attendance at another set of classes during the winter session.

In their second winter dental students are allotted another head and neck, in which they are expected to dissect, besides the muscles and ligaments again, the vessels, nerves and other soft parts, and also to acquaint themselves with the anatomy of all the special regions of this part, *e.g.*, the orbit, mouth, pharynx, etc.

Mr. Rowlands holds anatomy classes for these students, throughout the winter session, in the dissecting-room theatre, on Mondays, at 3 p.m., and a test examination is held on the work at the completion of the dissection and the course of demonstrations. It will be agreed that the second dissection is even more important than the first, and it is well to realise that, as the work done by each man is noted and marked every week by Mr. Rowlands, and men are only signed up for the necessary session's work when these marks are satisfactory, that careful and conscientious dissection, punctual attendance at demonstrations, and industrious reading up of all the work, must be begun as soon as the dental student enters the dissecting-room, and continued until the subject is mastered.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An attempt to "cram" it from books is certain to result in disaster.

C. H. F.

PHYSIOLOGY.

Physiology, which treats of the working of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology consists chiefly in the application of the natural laws elicited by the researches of physicists and chemists to the explanation and description of the phenomena occurring in the living body, so that an acquaintance with the chief laws of physics and chemistry forms the necessary basis for the study of physiology. The difficulty and importance of this subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years, which are devoted to the subjects that are preliminary to the work in the wards. On this account, the student beginning his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possibly opportunity, and he may profitably combine with the biology lectures and classes the reading of some elementary work on physiology, such as Huxley's *Elementary Physiology*, or the smaller work on the same subject by Foster and Shore. He is advised to attend the physiology lectures at this time, but cannot be signed up for them.

By the ordinary student the practical study of the subject included under the heading "Physiology" is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room three times a week; each class lasts two hours, the first half-hour being taken up by a short lecture, in which the tissues to be studied in the following practical work are described. This lecture will be held in the physiological theatre. Students attending this course must provide themselves with a compound microscope,* certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes. The microscope must have two objectives, a $\frac{2}{3}$-inch and a $\frac{1}{6}$-inch, a nose-piece and an indicator fitted to one of the two eye-pieces. The following makers are recommended: Crouch, Zeiss, Ross, Leitz (English agent, Kanthack), Swift. From any of these latter firms a good microscope, with all necessary accessories, can be obtained for about £7; the microscope from inferior makers is worse than useless, and it is essential that the student should buy an instrument which will be of some use to him in future years, when as a practitioner of medicine he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis.

At the end of the summer session an examination, written and practical, is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be allowed to enter for a similar examination at the following Christmas, but will not be able to present themselves for the second conjoint under six months from the time at which they passed this examination.

During the first summer session and the first half of the second winter session the student must attend regularly the lectures on physiology held three times a week, on Mondays, Wednesdays, and Saturdays at 10 a.m. During the same time those who have passed the histology examination at the end of the previous session must attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he must read up the subjects in some elementary text-book, such as Starling's *Elements of Human Physiology*, or Halliburton's *Handbook of Physiology*.

During the winter session, *i.e.*, from January to March, students must attend the classes in practical physiology, which are held on Friday and Saturday mornings from 11 to 1. From October to Christmas physiological chemistry is worked at in the room devoted to that subject. While attending this class, they are recommended to read up the subject in Halliburton's *Essentials of Chemical Physiology*, or *Practical Physiology* by Beddard, and others which are used as guides in the practical work. From January to March the class is held in the histological laboratory, where the student becomes practically acquainted with physiological apparatus, and performs simple experiments.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London or other Universities. Having passed their preliminary

* The demonstrators will be very pleased to advise any student in the purchase of a microscope. It must be distinctly understood that antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are practically useless.

scientific before entering, they are free from the study of biology during their first winter session. They should therefore attend the physiological lectures during this session, at the same time studying the subject in Starling's *Physiology*. In their first summer they attend the histology classes, but should supplement Schäfer's *Essentials of Histology* by reading the fuller accounts of the subject contained in Quain's *Anatomy*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. During this session they are recommended to read up the subject in Stewart's *Manual of Physiology* and Bunge's *Physiological Chemistry*, using Halliburton's *Essentials of Chemical Physiology* or *Practical Physiology* by Beddard and others, as the guides in the advanced practical physiology. This class should also be attended by candidates for the first F.R.C.S. examination, although in their case attendance may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Intermediate M.B. of London.

Those who are desirous of obtaining honours at the Intermediate M.B. should supplement the course of reading already indicated with original papers in the *Journal of Physiology* and with parts of Schäfer's *Textbook of Physiology* and of Gamgee's *Physiological Chemistry* Such students will also find parts of Foster's *Physiology* extremely useful and suggestive. University students should also attend the lectures given on Physiology at the London University.

Revision classes are held by the demonstrators during the two months' preceding the first F.R.C.S. and first M.B. examinations for the special preparation of candidates for these examinations.

List of books recommended:—

FOR COLLEGE MEN.—Schäfer's Essentials of Histology; Starling's Elements of Human Physiology, or Halliburton's Handbook of Physiology; Halliburton's Essentials of Chemical Physiology; Practical Physiology, by Beddard and others.

FOR UNIVERSITY MEN.—Stewart's Manual of Human Physiology; Bunge's Lectures on Physiological Chemistry; Histological and Embryological parts of Quain's Anatomy.

BIOLOGY.

The course of lectures and demonstrations for the requirements of students preparing for the first Conjoint examination is given in the long room, class room No. 2, at 2 p.m., Wednesdays and Fridays. The practical class will be held immediately after the lecture, and the new student is reminded that it is most important for him to attend both lecture and practical class from the *very first*, to obtain the knowledge in biology requisite for the Conjoint examination. The very closest attention to his work, more especially *in the practical part*, is necessary if the pupil would become familiar with a subject which, seemingly of not much value to him now, will be of no inconsiderable assistance in later work, particularly in the domain of morbid histology and bacteriology.

The first lecture will be given by Dr. Stevens, in the long room, class room No. 2, at 2 p.m., *October 3rd*. For the practical class, the requisites, of which a complete list is given below, must be obtained *beforehand*. We recommend new men, with reference to the purchase of a microscope—perhaps the most important consideration on entering these classes—that it should be deferred until one of the demonstrators has been consulted. We may state that microscopes are not absolutely necessary for the early classes, so that the purchase of one may be safely withheld until full instructions have been received from the demonstrators.

The special course of lectures and demonstrations devoted to the Preliminary Scientific examination of London are held on Wednesdays and Fridays at 10.30 a.m. The first lecture will be given by Mr. Assheton on Wednesday, October 1st, in the theatre in the pathological museum block of buildings. "Pre. Sci." men will require the set of requisites that are notified below.

With regard to this list, we have already referred to the "microscope." In purchasing a "dissecting-case," students must understand that an ordinary (human) anatomical set is *all* that is required. The special "biological set" is by no means necessary for the elementary work required at Guy's, and is, therefore, a needless expense.

REQUISITES FOR THE PRACTICAL BIOLOGY CLASS.

Every student attending these classes must provide himself with a microscope fitted with a double nose-piece. Crouch's student's microscope with ⅔rds and ⅛th objectives, two eye-pieces and a double nose-piece, in mahogany case, price about £7 10s., is strongly recommended. It can be obtained from Mr. Crouch himself, or from Maw, Son & Sons, Aldersgate Street. If a foreign pattern of microscope is preferred, Zeiss's or Leitz's is to be recommended, and can be obtained of Stanley, London Bridge; R. Kanthack, 18, Berners Street, W., or of Baker, 244, High Holborn. These microscopes are slightly more expensive than Crouch's. A cheaper microscope, which will serve the purpose, can be obtained from Messrs. Beck, of Cornhill, if preferred.

It will also be necessary to have the following:—Three small white saucers with flat bottoms; three watch-glasses ground on convex surface; two section lifters; three needles in handles; a pair of microscope scissors; ½-oz. No. 1 ¾-inch cover glasses; a gross of glass slides; a packet of labels; a small piece of soft silk; fine curved forceps; a "Seeker"; an anatomical dissecting case; a razor for cutting sections.

HONOURS IN ZOOLOGY.

A special course will be given in Zoology for students who may desire to take honours in that subject, full particulars of which can be obtained at the office of the Medical School, or from Mr. Assheton.

CHEMISTRY AND PHYSICS.

It is impossible to acquire a knowledge of chemistry or physics without personal and practical contact with the experimental side of these sciences, and Guy's men have, in the roomy laboratories, unusual facilities for this purpose.

Conjoint men entering now should pass in chemistry and physics next Easter, and should therefore attend the lectures in chemistry from October to March (Dr. Wade Tuesday and Thursday at 12.15), and the lectures on physics from October to Christmas (Professor Reinold Monday at 12 and Friday at 2). They must be prepared to devote a large amount of time to laboratory work. The practical classes are held in the chemical laboratory twice a week (Dr. Wade, Mr. Ryffel, and Mr. Ball, Tuesday and Thursday from 10 to 12), but students have access to their benches at all hours, and are advised to make free use of this privilege if they wish to make satisfactory progress. The first class of the new session will commence at *10 a.m. on Thursday, October 2nd*, when *all Conjoint Students* should attend; the first lecture at 12.15 on Tuesday, October 7th. Revision classes are held before the April, January and July examinations; admission to these classes is dependent on the student passing the test examinations in a satisfactory manner.

Dental students under the new regulations are required to go through the same course as the Conjoint men, and to pass the same (Preliminary Science) examination; they should attend the laboratory class at *10 a.m.* on *Thursday, October 2nd.*

Special courses have been arranged for most of the University examinations. Candidates for the Preliminary Scientific (M.B.) examination of the London University attend the same chemistry lectures as the Conjoint men, but the physics lectures are continued throughout the sessional year (Professor Reinold, Monday at 12, Friday at 2). The Preliminary Scientific class meets for work twice weekly in the chemical laboratory (Dr. Wade, Mr. Ryffel, and Mr. Ball, winter and summer, Tuesday and Thursday 10 to 12), and twice weekly in the No. 1 physical laboratory (Mr. Ball: winter, Tuesday 2 to 4, Friday 3 to 4; summer, Monday and Thursday 2 to 4); *but students are expected to spend all their spare time in one or other of the laboratories.* It cannot be too often or too strongly urged that reading without laboratory work is mere waste of time. Tutorial classes are held weekly in both chemistry and physics, and are supplemented by revision classes during the term preceding each examination, and by periodical test examinations. Students intending to work for Honours in either subject should consult the demonstrators.

Intermediate M.B. men who have just passed the Preliminary Scientific examination should begin to work at organic chemistry at once if there is room in the laboratory. The practical class meets twice weekly in the laboratory throughout the year (Dr Wade and Mr. Ryffel: winter, Monday and Thursday 2 to 4; summer, Tuesday and Thursday 2 to 4) and is supplemented by lectures, revision classes, and periodical test examinations. A course of experimental lectures for beginners will commence on Friday, October 3rd (Dr. Wade, chemical theatre, 10), and a more advanced course for second year's men and others on Wednesday, October 8th (Dr. Wade, chemical theatre, 1.15).

Oxford, Cambridge or Durham students desiring to work at chemistry should communicate with the demonstrators.

The practical knowledge of toxicology required at the degree examinations of the London and other Universities may be obtained at classes held by Mr. Ryffel during the latter part of the winter and summer sessions. W.

PRACTICAL PHARMACY, MATERIA MEDICA, DISPENSING.

These subjects are taught in the practical pharmacy class at the hospital dispensary, by Mr. Finnemore. This course meets the requirements of students preparing for the Conjoint examination in practical pharmacy, and the intermediate M.B. Lond. The study of the physical characters, and chemical properties of substances used in medicine, and preparations made from them, and the doses in which they may be given, requires some considerable amount of application and exercise of memory. The instruction given in the class is therefore very practical, and every assistance is given to the student by demonstrations, access to materia medica specimens, and *vivâ voce* examinations, in acquiring a sound knowledge of materia medica. The art of dispensing, the writing of prescriptions, and the methods of prescribing drugs, form also part of the instruction given in the practical pharmacy class. During the year there are three courses of three months each, so that the student can enter at the time most convenient to him.

PHARMACY, PHARMACOLOGY AND THERAPEUTICS.

Lectures are given during the summer session in the anatomical theatre, by Dr. Perry. This course is intended to meet the requirements of students preparing for the third Conjoint examination in pharmacology and therapeutics, for the intermediate M.B. and final M.B. Lond., and the third M.B. Cambridge. C.

MEDICINE.

Medicine lectures are held on Mondays and Fridays, at 4 p.m., and Wednesdays at 3 p.m., in the anatomical theatre, throughout the winter session, by Dr. Taylor and Dr. Hale White. The introductory lecture will be given by Dr. Taylor, on Wednesday, October 1st, who will then proceed to discuss "Fever, Contagion and Specific Diseases."

A clinical lecture is delivered every Saturday, at 1 p.m., in the physiological theatre, the first of which will be given by Dr. Pitt, on Saturday, October 4th. These

lectures are held at 1 p.m., so as to enable footballers to attend, and they finish in time for them to catch the 2.23 train to Honour Oak Park.

THE MEDICAL WARDS.

Clinical instruction in medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the physicians, who visit their cases from 2 to 5 p.m., and by the medical registrars in the mornings from 10 a.m. to 1 p.m. There are two male wards, Philip and Stephen, each containing forty beds, and one female ward, Mary, containing fifty beds and six cots. The latter is divided into four divisions, each physician taking one division. Dr. Taylor and Dr. Hale White divide the beds in Philip ward between them, and Dr. Pitt and Dr. Perry those in Stephen ward. On Mondays and Thursdays the wards are visited in the afternoon by all the physicians; on Tuesdays by Dr. Hale White and Dr. Perry; and on Saturdays by Dr. Pitt. The medical registrars see new cases in all the wards on Monday and Thursday mornings; on Tuesday Dr. Taylor's cases; on Wednesday Dr. Hale White's; on Friday Dr. Pitt's; and on Saturday Dr. Perry's. Thirty-six medical ward clerks are appointed every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties.

Case-taking.—Reports are made by the medical ward clerks on all the cases admitted to the wards, under supervision of the medical registrars, who instruct the clerks in the mornings in the method of case-taking and the physical examination of the patients. To each physician is appointed a clinical assistant, who superintends the writing of the reports and helps the clerks in any special examination of blood, urine, etc., which may be necessary.

The reports are written on special sheets, kept for the purpose in each ward, and the name, age, address, etc., of the patient should be carefully filled in, as well as any previous admissions into the hospital. In the latter case the abstract of the old report should be copied into the new report. Details as to how to find an old report will be found posted on one of the cupboards in the medical registrar's room, but if the previous admission was in the current year, reference should be made to the registrars for the report. Ward clerks should always make brief abstracts of the case at the end of the report, and in case of death the post-mortem abstract should be copied in, and when the report is finished it should be handed to the clinical assistant, who eventually sends it to the medical registrar. Where possible it is as well to put in the report what the physician said about the case, and especially his diagnosis, but clinical teaching on the disease in general should not be recorded, and great care must be taken to report the physician accurately.

Temperatures.—The temperature of the patients must be taken and noted every morning by their respective clerks. Evening temperatures are taken by the clerks in turn; the dates of this duty will be found on the notice-board in the central hall of Mary ward. The temperatures to be taken will be put on a card hanging on the wall in each division.

Classes.—On Thursdays classes are held for all medical ward clerks at 12 o'clock, in the surgical class-room, on the methods of medical diagnosis, and the explanation of physical signs, etc. During the first six weeks of each three months, classes are held in the clinical laboratory for the junior clerks on the practical examination of urines and blood, and the use of the ophthalmoscope, laryngoscope, and other apparatus. During the last six weeks practical classes on ophthalmoscopic work are given by the ophthalmic and medical registrars.

The times of the classes will be found posted in the hall of Mary ward.

The Clinical Laboratory (opposite the lift in the medical buildings) is intended for those investigations which cannot be done in the ward. A microscope and a centrifugal machine, and special reagents are kept there, and examination of sputum, gastric contents and all qualitative analyses should be done there.

Several special reagents and blood stains are kept by the medical registrars locked up, and can be had from them on application.

Medical Instruments.—A larygoscope and cyrtometer are kept in Mary ward, and can be had, on application, from the Sister. Instruments for examining blood are provided in Mary, Philip and Stephen wards.

Tubes for taking cultivations, and pipettes for holding blood for Widal's serum reaction in typhoid fever, can also be had from the Sisters of the wards, but these should not be used except with the help of the clinical assistant or the house-physician.

It is very important that the clerk should find out the result of the investigations made by the bacteriologist and record it in the report.

A few practical hints.—Never lose an opportunity of examining a patient for yourself, and then find out what you ought to have noticed. It is only by constant practice that you can train your senses to appreciate the signs of disease, and without this skill, mere book knowledge is valueless. Therefore, listen to the normal as well as the abnormal, and get into the way of examining your cases with some method, so that you have an intelligent idea of what you are trying to find out. Although only a few cases are under your immediate care it is not intended that you should limit your observations to these, but you should know well all the cases under your physician, and something about all the interesting ones in the medical wards. To do this, when your own cases have been attended to, you should go round with the registrar, or examine the patients allotted to other clerks, and ask what points of interest there are about each case. Also, when your physician is not going round, attend someone else's clinical instruction,

either in the wards or at out-patients. Above all, remember that many of the patients think you to be a "doctor," and treat them as patients, and not as pathological specimens. You cannot be too gentle in an examination of a patient, nor too considerate for the feelings of a sick person. Remember, too, that though the post-mortem room should not be mentioned before patients, yet it is there that you will learn a great deal of medicine, and for you to know your business thoroughly you should never miss an opportunity of seeing the organs whose condition you have tried to make out during life.

As regards reading, Taylor's or Osler's Medicine are the best books, and at first you should read up your own cases and then others as you come across them. Hutchinson and Rainey's Clinical Methods, or Gibson and Russell's Outlines of Physical Diagnosis will also help you very much. M. R.

PATHOLOGY.

The large number of courses of instruction in pathology given in the school leads to some uncertainty in the student's mind as to the order and period of the curriculum in which they should be taken. Pathology is one of the few good things of which it is impossible to have too much, and probably the best advice that can be given to a student who has passed his second conjoint or Intermediate M.B. is to take the instruction in pathology which is offered to him as early and often as possible. Most of the instruction in pathology is given in the early morning, so that it shall clash as little as possible with work in the wards, and it is rarely advisable to postpone attending a course till the time arrives, which many seem to expect but fortunately seldom reach, when ward duties shall be less exacting than they are at first. A man who leaves the dissecting-room in April should begin to attend Dr. Pitt's systematic lectures on pathology in the following summer session (Anatomical Theatre, Saturdays at 9), where he will be introduced to the great principles underlying pathological processes, and will learn something of the theories of disease, which will enable him to understand the facts revealed to him in the post-mortem room. He should remember that this course of lectures is not completed in one year, and that if he attends the lectures for three consecutive years he will each time hear different subjects treated of. If it is in the summer session that a student is released from his anatomical studies, he should begin to learn pathology at the winter demonstrations (Dr. Fawcett and Mr. Steward, Monday, Wednesday and Saturday, 9.15, in class-room No. 2). Here he will be introduced to the treasures of the pathological museum. Selected specimens will be brought from the shelves of the museum for his inspection, and the effects of pathological changes upon the various organs of the body will be demonstrated. The subject is roughly divided into medical and surgical pathology, two days a week being devoted to the former and one to the latter. The whole course occupies two years. At the end of each half-hour demonstration on museum preparations, a *vivâ voce* examination is held on typical recent specimens collected from the post-mortem room and operating theatre.

Valuable as is the instruction afforded by these systematic lectures and demonstrations, they must on no account be allowed to take the place of the daily demonstrations of Morbid Anatomy (Dr. Bryant and Dr. Fawcett, 2 p.m.) in the post-mortem room. Here a student gains information on the relative distribution of morbid processes throughout the body, and learns to verify the accuracy of his observations at the bedside. No ward clerk must on any account neglect to follow the fatal cases to the post-mortem room, and throughout a student's career there is probably no more profitable way of spending an afternoon unappropriated to routine duty than in watching post-mortem examinations. It is not always possible to find time to hold the appointment of post-mortem clerk, but whenever it is the appointment should be held. The man who misses the opportunity while he is at the hospital of becoming acquainted with the many difficulties that may be encountered in making a post-mortem is sure to regret it afterwards.

The practical use of the microscope in solely pathological problems should be learnt as early as possible. With this object the course of Microscopical Pathology (Mr. Bellingham Smith and Mr. Eyre, Tuesday and Friday at 9, in the New Histological Laboratory) should be attended in the first winter session after the student gets into the wards. Here he will gain his first instruction in practical Bacteriology, which he will have constant opportunities of making use of in the wards. Here he will also amplify the knowledge he has already acquired, in the course of Normal Histology, of section cutting and staining, and have demonstrated to him the microscopical appearances of tumours and diseased tissues. A man cannot often find time to attend this course more than once, but he should attend it early in his career and work hard to learn enough about technique to enable him to afterwards examine specimens that constantly come in his way while holding senior appointments. Morbid histology and bacteriology are very engrossing studies, and many good men fight shy of them on account of the amount of time they fear they will "waste" over them. But a man of method can generally find a good many spare moments to devote to this work without seriously interfering with his reading, and he who acquires the hobby will find it a useful one to ride when he has accomplished his examinations and is waiting for patients.

BACTERIOLOGY.

The compulsory course in Bacteriology forms part of that in microscopical pathology. As in previous years, the first two months will be occupied with this subject. The rudiments of the science are taught; the methods of staining sputum, pus, etc., to demonstrate bacteria;

the methods of collecting morbid products for bacteriological investigation; in fact, the technique of the examinations which can be undertaken in the wards.

A course is also held in the Bacteriological Laboratory during the months of November and December, covering practically the same ground, and is largely intended to meet the requirements of qualified men, and students other than Guy's men.

Two optional systematic courses, each of about two months' duration, are held, beginning in January and May respectively, and especially intended for Final M.B. men and candidates for the Diploma in Public Health. The course consists of lectures and demonstrations of morbid secretions and excretions, water, air, protozoa, etc.; susceptibility, immunity, etc. The students are instructed in the practical details of media making, culture, staining, etc, and they examine the more common pathogenic and non-pathogenic bacteria.

SURGERY.

Lectures are held three times a week, on Mondays, Wednesdays and Thursdays, at 9.30 a.m., by Mr. Lucas and Mr. Golding-Bird.

Mr. Golding-Bird for the first part will lecture on "General Surgery," commencing on Thursday, October 2nd. Clinical lectures will be given on Mondays, at 1.30, in the physiological theatre, by the surgeons. Mr. Lucas will commence on October 6th. After November 10th the day for the clinical lecture will be changed to Monday.

Mr. Dunn, six weeks before the final Conjoint examinations in January, April and July will hold "Revision Classes," upon which attendance is voluntary. Only those desiring to present themselves for examination are expected to attend.

Mr. Dunn will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1903, and the fee of 10s. 6d. should be paid not later than December 18th. Names of students desirous of attending the M.B. course, should be left at the medical office *before* the end of September. Mr. Higgens will lecture during January to March on "Ophthalmic Surgery," on Wednesday, at 9 p.m., in the ophthalmic operating theatre. The lectures must be attended after passing the second Conjoint examination before admission to the final Conjoint.

Mr. Jacobson holds a Clinical Class on Wednesdays at 2 p.m., in the large operating theatre, for the benefit of candidates for the Conjoint and other examinations in surgery. The classes have proved since their commencement a marked success, and should be attended by all students entering on their final examinations in surgery. We are informed, on good authority, that at least one other member of the surgical staff intends to hold similar classes during the winter session.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as a clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards He will find, however, that by paying attention to the advice we give him, that his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the hospital, there is a tendency in the minds of some, and a little more than a tendency in the minds of others, to belittle the post. This is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this: the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical wards falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has, on the whole, been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards is of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks to instruct them of their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be

judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. The firm should see that he represents it fairly.

The clerk, as soon as he is appointed, should find out from the surgical registrar to whom he is appointed. A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work.

He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress upon each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

A new departure was made two years ago in the practical surgery classes, which are in the hands of the surgical registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Tuesdays and Fridays are reserved for operations, notice of which has been posted in the colonnade. The surgeons are assisted at the operations by the dressers, and no others should stand about the well of the theatre, the only exception being the particular ward clerk to the case. With due diffidence we should like to hint that the front seats reserved for the staff and for visitors were never intended to be used as a footstool. The habit of sitting perched along the front rail is one of recent growth only, and in the interest of the patient, the operator, and those watching the operator it is to be deprecated.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of every one in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfills his own function, each at the same time being dependent on the others for the smooth, even working of the whole.

S. R.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Taylor (2), Mondays, Thursdays and Fridays. Dr. Hale White (2 Mondays, Tuesdays,

Thursdays and Fridays. Dr. Pitt (2), Mondays, Tuesdays, and Fridays. Dr. Perry (2), Mondays, Thursdays and Fridays.

Surgical Wards.—Mr. Lucas (2), Mondays, Tuesdays, Thursdays and Fridays (1.30). Mr. Golding-Bird, Mr. Jacobson, Mr. Symonds (1.30), Mondays, Tuesdays, Thursdays and Fridays. Operations daily (1.30).

Obstetric Ward.—Dr. Galabin (2), Mondays and Thursdays. Dr. Horrocks (2), Tuesdays and Fridays.

Ophthalmic.—Mr. Higgens (2), Fridays. Mr. Brailey (2), Tuesdays. Operations (2), Mondays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows :—

Medical Cases.—Dr. Shaw (1), Fridays. Dr. Bryant (1), Mondays. Dr. Fawcett (1), Thursdays. Dr. Beddard (1), Wednesdays.

Surgical Cases.—Mr. Lane (1), Mondays. Mr. Dunn (1), Wednesdays. Mr. Fripp (1), Thursdays. Mr. Steward (1), Saturdays.

Obstetric.—Mr. Targett (1), Thursdays and Saturdays.

Ophthalmic.—Mr. Higgens (1.30), Mondays. Mr. Brailey (1.30), Tuesdays and Fridays.

Dental.—The Dental Staff (9), every week-day.

Aural.—Mr. Fagge (1), Tuesdays.

Skin.—Dr. Perry (1), Tuesdays.

Throat.—Mr. Steward (1), Fridays.

Electricity.—Dr. Bryant (1.30), Wednesdays and Thursdays.

DENTAL SCHOOL.

The dental student is supplied at the medical office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

If these pamphlets are carefully perused, he will become well acquainted with the general arrangements of the school, and the scope of the work upon which he will be engaged during his studentship.

It will first be necessary for him to purchase his instruments at one of the dental depôts, and to satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course is conducted by the staff demonstrators, and is very comprehensive. It includes most of the conservative operations that the student will subsequently perform on patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. If the manipulations upon the dummy are done in a thoroughly sound manner, a capital groundwork of operative dentistry will be acquired. It may be mentioned in passing that too much stress can scarcely be laid upon the necessity of becoming an expert operator, for the public are not slow to appreciate the highest manipulative skill.

The regulations of the Royal College of Surgeons of England require that dental students, who registered on and after January 1st, 1897, shall pass two professional examinations for the dental license. At the first professional examination certificates must be produced *inter alia*, of having been engaged in the practice of dental mechanics under a registered dental surgeon during a period of three years, and of having manufactured and adjusted six dentures and six crowns.

Inasmuch as it is recommended at Guy's that this examination be passed during the month of May, it follows that the work of the first winter session must be largely devoted to demonstrations, dental mechanics, metallurgy, and lectures.

If a student needs help or advice in his work he should consult the Dean, or a member of the Staff, any of whom will gladly do what he can for the best interests of the student.

M.

Jottings in General Practice.

ACUTE GENERAL PERITONITIS; RECOVERY.—Annie K., æt. 26, was taken ill on 29th June with "shivers" followed by vomiting watery stuff, and diarrhœa. The evening before she had been boating with her fiancé. A period stopped short at three and a half (instead of seven) days. Twenty-four hours after the onset the pulse was 112–120, respiration 56, and temperature 103·2°. There was severe pain over the lower half of the abdomen, and distension rapidly appeared. Although vaginal examination threw no light on the case, it appeared more probably one of pelvic or uterine origin, though once or twice there appeared to be distinctly more pain on the right side, not so very far from the appendix. The case was a tedious one, convalescence being retarded by at least two relapses, which spun it out to two months. Invalid diet and then peptonized preparations being equally unsuccessful, rectal feeding had to be entirely relied upon for about a fortnight, the other treatment consisting of soap enemata containing ol. terebinth ʒj. every four or five days, and opium gr. ½ in pill every three or four hours. Recovery when it did occur was most satisfactory. The case well illustrates the difficulties of dieting and nursing such a patient two miles off, in a cottage where one has only friendly neighbours to rely on, and where a bed-pan is looked upon as a bad successor to the traditional "dose of salts," and brandysnaps and strawberries are administered without consulting the faculty.

ACUTE GENERAL PERITONITIS; COLLAPSE ON THE FIFTH DAY.—Mrs. T., æt. 51, after a stroll on the pier-end on a cold evening was seized at 4 a.m. with intense pain about the umbilicus and especially in the back, and bilious vomiting. Three injections of morphia in succession were necessary to check this pain with which an intolerable restlessness was associated. The pulse kept about 112, and the temperature, which was 97° in the morning, became 99·4° later in the day as she rallied and her general condition improved. Resonance became impaired in both flanks, and vaginal examination shewed the right lateral fornix to be more resistant, more tender

and reaching lower than the left, but no ovarian or other tumour could be felt; when first seen the abdomen was collapsed and flaccid, and any tumour would probably have been recognised. An injection containing turpentine was retained without any further result, but the lack of prominence in the sickness, which was at no time fæcal, argued against obstruction. Ice was tried as the result of a consultation and certainly relieved some of the thirst and distress, though it probably added to the collapse. Passing a rectal tube about eighteen inches gave no relief, and the most intense pain came on again in the back on the fifth day. She sank rather suddenly about three-quarters of an hour after an injection of morphia. No satisfactory solution of this pain in the back was ever arrived at; it somewhat reminded one of a case or two in which renal thrombosis occurred shortly before death. The dark portery vomit ejected just before death was so putrid that the smell could be recognised across the street, and decomposition was said to be correspondingly rapid.

ABSCESS BEHIND THE SHEATH OF THE RECTUS MUSCLE RESULTING FROM PERITONITIS EIGHTEEN MONTHS PREVIOUSLY.—Hannah B., a weakly looking girl, æt. 26, but with a healthy family history, complained of increasing abdominal pain for the last two weeks. The temperature ranged about 99·8° and there was a very tender rather indefinite swelling to be felt just to the left of the umbilicus. Exploration shewed this to be a collection of rather thick creamy stinking pus, without any caseous matter in it. After the sheath of the rectus had been opened and the muscle-fibres separated longitudinally, the *posterior* layer of the sheath had to be cut through before the matter was reached; this made it more likely to be attributable to the previous illness, but no history of an injury or strain or other exciting cause could be obtained. Healing was complete in four and a half weeks, the only difficulty being to prevent the muscle-fibres from adhering before the cavity had become filled up.

ACUTE LOCAL PERITONITIS; DOUBTFUL WHETHER PELVIC OR PERITYPHLITIC.—This case in a young lady æt. 21, puzzled one extremely to decide its exact origin as it combined the following features in favour of a pelvic source, viz.:—Acute onset with a presumed chill during a period, pain in both iliac regions, frequent micturition, little tendency (relatively speaking) to sickness; while on the other hand the pain ultimately localized itself to two or three inches above the lower end of the ascending colon, where an indefinite thickening could be felt for two days, and the peel of a pear was afterwards mentioned as having possibly contributed to the attack. A rectal examination did not reveal any pelvic tenderness or swelling. She made an uninterrupted recovery in a fortnight, but the pulse was 120 when first seen.

MINOR EPILEPSY.—A single lady, æt. 34, complained of not having felt well for a few days, and having tumbled down about twelve stairs in some unaccountable sort of way. A day or two later she fell out of bed in the same mysterious way. She had not actually gone to sleep, but her mind was a blank until she heard and felt her head bump, and found herself on the floor some distance from the bed. She admitted having on one occasion "fainted" three times, which attacks were followed by a bad headache, and this, as might be expected, also occurred on this occasion. No signs of organic heart disease could be discovered, and as there was no reason to suspect the lady of alcohol the above appeared the most probable explanation. She did not wet herself during the period of unconsciousness, and was sure she never "walked" in her sleep. Treatment with KBr and borax appeared to prevent the occurrence of any more attacks.

TRAUMATIC EPISTAXIS AS A THERAPEUTIC MEASURE:—

1. An old gentleman, over 90, living in a country village, used to smite himself on the nose every now and then when he "thought it would do him good."

2. A gentleman, æt. about 40, but looking 50, residing near London, adopted a similar measure as a remedy for the stuffy feeling in the nose due to an ordinary cold. As he shewed signs of high arterial tension and had gouty symptoms and lived a fast life, the loss of blood was in some ways beneficial. It recurred, however, two or three times spontaneously and this led him to seek advice. Syringing the nose regularly with diluted Ext. Hamam. Destillatum stopped this and cleansed the passages, making it feel correspondingly clearer.

Although the above cases illustrate no new point that I am aware of, I think these jottings may be of interest to some. Personally, I think the continued publication of new diseases, newer remedies, and "Oh! my gracious!" cases in general in the journals is perplexing, if not boring, and calculated to give one quite a wrong impression as to the incidence of disease in general.

A case of syphilitic arteritis in an artist, æt. 34, leading to sudden and well-marked right hemiplegia with moderate optic neuritis (left), but no pain, shewed considerable improvement at the end of a month, aided by Faradism begun on the twelfth day, and active iodo-mercurial treatment throughout, but I need not describe the case at further length as, in my time, nervous cases were rather looked askance at in general hospitals, perhaps as not repaying the difficulties and intricacies of their pathology and diagnosis.

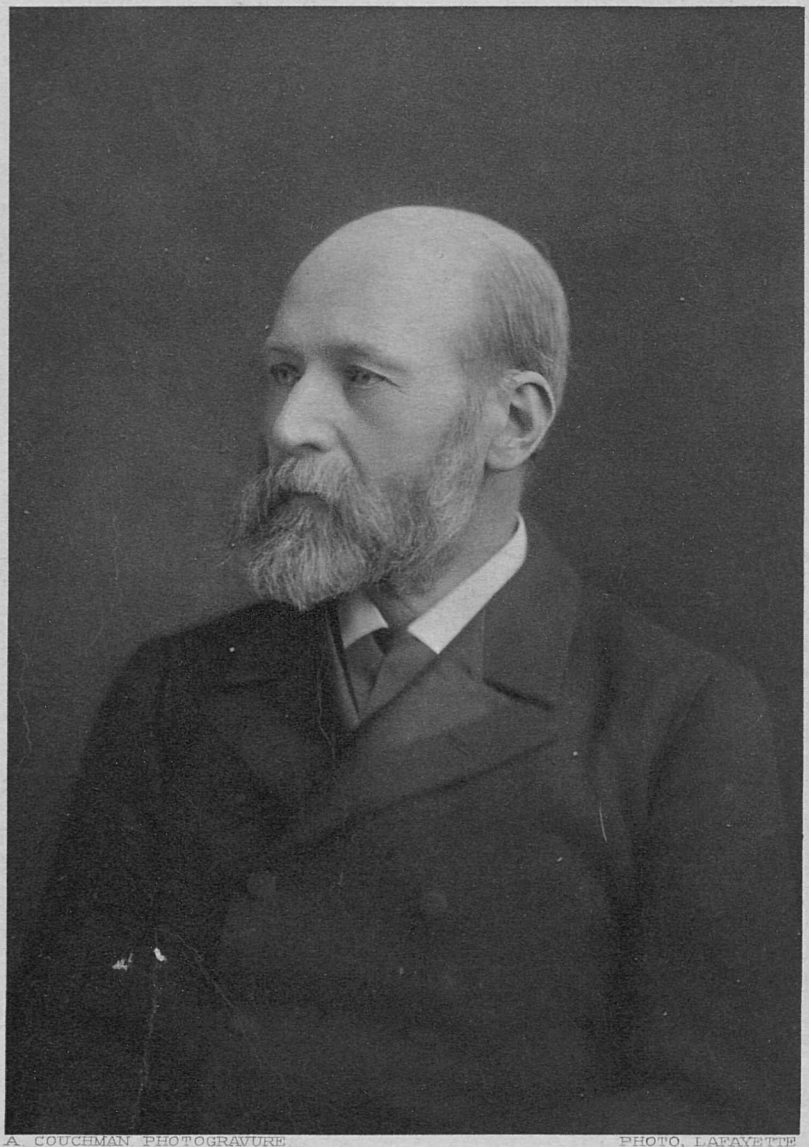
Whitby, Yorks. A. J. SHARP.

Papers by Guy's Men.

On the Products of the Proteolytic Action of an Enzyme contained in the Cells of the Spleen. By J. B. Leathes, M.B., B.Ch., F.R.C.S.—*The Journal of Physiology*, September, 1902.

The Mechanism of Pancreatic Secretion. By Professor E. H. Starling, F.R.S.—*Ibid.*

With Dr. E. W. Ainley Walker at Guy's Hospital.—*The Clinical Journal*, 24th September.



A. COUCHMAN PHOTOGRAVURE PHOTO, LAFAYETTE

Yours faithfully
H. G. Howse.

Passim.

To the many new men who are shewing their good sense by coming to Guy's this October, we would extend a hearty welcome. We have elsewhere already offered a few words of advice, and would here only weigh in with the well worn, but ever true adage—"Work hard and play hard." Both are essential, and neither is unpleasant.

The Rev. J. Scott Lidgett points out in a letter which will be found in the correspondence column, that there are a few vacancies for residents at the Bermondsey Settlement, of which he is the Warden; he writes at an opportune moment for the benefit of such men as are coming up to Guy's this year, and have not yet heard of this institution. The Settlement, which has now been at work for ten years, aims at raising the social, moral, and educational tone of the neighbourhood in which it has been established; for this purpose classes and lectures of many kinds have been arranged, and each of the fifteen or twenty residents of all professions and callings who live at the headquarters gives what help and time he can spare to the furthering of any branch to which his inclination leads him. One of the truest and most serious charges brought against the average medical student is his apparent inability to drag himself out of the clayey furrow of medicine and surgery which he ploughs; the severity of the work, and the loneliness of his life in diggings, all tend to produce a one idea'd man. To avoid this it is necessary to have some other interest in life than the anticipation of examinations; certainly these would not suffer by allowing one's mind a little broader scope than that which a mere bookworm permits. At the Settlement this other interest is provided, and one comes into contact with men of other professions and other thoughts, all of which is good.

There is of course no compulsory call upon a man's time, and a resident may do as little or as much as he pleases, but for such as have a thought for the social problems of the life of our London poor, and who are anxious to do even a little to improve it where they can, the Settlement offers a unique opportunity. And surely there must be many such in a community such as our own, brought closely into contact, as we are, with all that is poorest and most wretched in all South London.

There is a well authenticated rumour that the Lord Mayor, who is to preside on Wednesday next, is going to do us the honour of coming in state with historic coach and coachman all complete, and with sheriffs in attendance. One of the features of the day which should prove an attraction to the numerous friends of the medical student who profess a devotion to science and its weirdities, is to be an exhibition of skiagraphic apparatus and its productions. This should prove a rival to the horrors of the museum amongst our lady friends. Men who have not received invitations to the Prize Day can get their tickets from the librarian.

A somewhat vague and mysterious process is at present in full swing; we refer to the enrolment of all London University men as 'internal students.' Although this means nothing in the present life of the University, it may mean a good deal in the future in the direction of assisting men to become members of social, literary, medical, or other clubs, and Dr. Fawcett has been at much pains to secure the inclusion of all who are eligible. Any London University student who is not upon the list of those for whom cards of registration have been obtained, should leave his name at the Medical School Office.

In our last issue we referred by inadvertence to Sir Henry Howse as Mr. Howse. The mistake was noticed when too late for correction, but we feel that no apology is needed from us to Sir Henry for the error. It is a proof to him, if proof be needed, that his memory is still green at Guy's Hospital, and when we would mention him we perforce refer to him by the old name which had grown so familiar among us.

A novel suggestion comes from a correspondent to the *Morning Post*. "We insure against

accidents; why not against operations?" There is a certain amount to be said for it at first sight from our point of view, and the surgeons would get their fees from many who are at present unable to repay. But the next step would be for the insurance companies to secure the services of a regularly appointed surgeon and the whole system would practically become a club. Then should we see laparotomies at a guinea and varicose veins at five shillings.

IT may not be uninteresting to Guy's men to know that Brother Prince, the founder of our newest and most ambitious sect, was himself a Guy's man before he became a second John the Baptist. There is hope for all. He entered Guy's in 1834, and took the "Blackfriars degree"; having done this he changed his mind and entered the Church. Had he remained to adorn our profession he would probably have made a fortune. What he might have lacked in skill and knowledge would have been amply atoned for by the fascination which he appeared to exercise over those unfortunates with whom he came in contact.

THE latest sensation in the College is a renewal of the old microscope snatching tricks. There have been in the past men who were unable to distinguish between other people's microscopes and their own, and who absent-mindedly pocketed ophthalmoscopes or any other saleable articles of interest which came in their path. These men have inevitably come to a bad end, and the sooner the present thief is detected and punished the better it will be for him and for us. Far be it from us to advocate illegal violence, but should the man be detected red-handed, let us hope it may be by the second strongest man on earth.

THE subscription list for the South African Memorial Fund will very shortly be closed, and any further subscribers should send in their donations at once. The President of the Residents has succeeded in raising the respectable sum of over £30 as the result of his collection amongst the various firms.

WITH the incoming month we shall have to part, with many regrets, with our President, whose excellent judicial nature and multitude of other good qualities have rendered him most popular with all. Mr. Greenfield, the Vice-President, has already departed to regions of lucrative holiday bliss which we can only imagine and envy. Messrs. Atkins and Robson, who are filling the vacant posts, are to be congratulated and welcomed. Messrs. Bowen and Brown we congratulate on their elevation to the position of House-Surgeons and initiation to the brotherhood of the Residents' Table.

A CURIOUS letter appeared in one of the morning dailies on the subject of operations and the payment of fees. The writer, presumably of the middle-class, whatever that may be exactly, advocates the application of middle-class patients for admission to general hospitals —firstly, on the ground that the hospitals were supported largely by the middle-class people, and secondly, because English surgeons charge exorbitant fees. In this connection she advocated the emigration of patients to Germany, where "surgeons of world-wide renown" will do laparotomies and any subsequent after-treatment required themselves for five pounds. The reason—we do not admit the truth of this statement—why the foreign surgeons can work so cheaply is that they do not want carriages, servants, dinners, etc., but live quiet and frugal lives. The interest in the letter lies in the intolerable insolence of the writer, who would retain in penury, for her own benefit and perhaps the benefit of her friends, an exceptionally gifted man, for the great surgeons, as we know them, are men of a large mental stamp. She apparently does not realise that a surgeon, in common with everyone else, is at liberty to place his wares—namely, his skill—in the most profitable market.

MR. STEPHEN COLERIDGE has been thinking again. He has discovered this time that vivisection, or rather the issuing of licenses to practice vivisection, has increased *pari passu* with the increase of cancer. From this he deduces that there is a causal relation between

cancer and vivisection. Whether the vivisection produces cancer in the vivisectionist or a cancerous patient is led to operate on live animals is not quite clear. We should have imagined that a much more effective, and catch-penny, article might have dealt with the relation between income tax and cancer. There is no doubt that the tax has gone up. May it not have led to an increase in cancer? Perhaps, however, Mr. Coleridge's income is not such as would be influenced by income tax—or cancer. This may account for his appalling oversight.

EVERY age has its land of promise, whose half-revealed delights and possibilities give free rein to the imagination: that of our own age is Uganda, the paradise of sportsmen and the hope of future colonists, in the heart of that Dark Continent of which England claims so large a share. All that is to be told of the country at present has been presented to the public by Sir Harry Johnson, but it is always of interest to hear of new lands from eye-witnesses whom we personally know. In another column we publish a short letter from a Guy's nurse who has been engaged upon a case out there. It is a matter of common knowledge that the sleeping sickness to which she refers has attracted the attention of Government, who have appointed a commission to investigate the disease; this commission is, and has been for some time, at work, and we may look forward in the course of the year to an interesting report.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. M. J. Rees, D. H. Trail, A. H. E. Wall, L. H. Moiser, F. H. Parker, O. W. Richards.

Clinical Assistant in Medical Out-Patients.—Mr. W. W. Read (Dr. Fawcett).

Obstetric Dressers.—Messrs. T. C. Lucas, M. B. Taylor (November 16th).

Dressers in the Throat Department.—Messrs. F. W. Fawssett, J. T. Hicks, N. N. A. Houghton, G. G. Davidson, B. Glendining, J. Goss.

Clerks in Throat Department.—Messrs. C. H. Denyer, E C. Myott.

Assistant Surgeons' Dressers.—Messrs. R. Franklin, W. S. Orton, J. D. Thomas (Mr. Lane); A. V. Maybury, A. F. Hertz, F. W. M. Palmer (Mr. Dunn); R. D. Bridger, F. B. Lowe, C. J. S. Dismorr (Mr. Fripp); R. M. Rendall, E. C. Myott (Mr. Steward).

Medical Ward Clerks.—Messrs. F. Barnes, J. H. Clatworthy, G. Russell, J. M. Barrionuevo, A. M. Benett, G. Cheyney, C. P. Harvey, D. Isaacs, J. McF. Pollard, J. E. Prentis, W. Reeve, H. D. Wyatt, W. N. May, E. W. Routley, W. M. Mollison, R. Felton, L. Doudney, A. Leeming, J. O. Musson, A. M. Roome, J. Cook, P. A. S. Dyson, R. Edridge, P. F. Minett, L. Myer, A. S. Littlejohns, S. M. Wells, E. C. Hughes, L. J. J. Orpen, C. M. Stevenson, H. M. Clarke, E. W. Sheaf.

Assistant Physicians' Clerks.—Messrs. J. E. Spiller (Dr. Shaw); G. Russell (Dr. Bryant).

Surgical Ward Clerks.—Messrs. N. H. Oliver, L. J. Patterson-Clavier, R. O. Williams, H. P. Costobadie, F. M. Longson, T. Turner, J. B. Ball, A. H. Clough, A. B. Cocker, G. F. Greening, F. H. Lennox-Jones, R. P. Lewis, H. V. Mitchell, J. E. Scales, W. Welchman, E. White, L. G. Davies, C. M. Wenyon, A. S. B. Bankart, R. A. Chisholm.

Aural Surgeon's Dressers.—Messrs. E. H. Griffin, B. I. Rahim.

Post-mortem Clerks.—Messrs. N. I. Spriggs, H. Watts, A. R. Brailey (October–November).

Chapel News.

The Harvest Festival will take place on Sunday, October 5th.

The services and preachers are as follows:—

Holy Communion at 6 a.m., 7 a.m. and 8.45 a.m.

Morning Prayer, 11 a.m. Preacher, Rev. A. J. Wethered, Vicar of Kingswood.

Evening Prayer, 7 p.m. Preacher, The Rev. W. F. G. Sandwith, Vicar of S. Barnabas, Kennington.

Collections will be made on that day for Foreign Missions and the amount will be divided between S.P.G. and C.M.S.

Hovis Food for Infants.

THE Hovis Company have prepared a special food for infants which has been tried in the hospital with success. There are several foods which are admissible for children of tender years, but individual idiosyncracies of infants sometimes prevent the employment of any. We therefore welcome the advent of another sound, scientific infants' food as giving us one more alternative.

Birth.

KEY.—On September 22nd, at 67, Victoria Road North, Southsea, the wife of Martin Aston Key, B.A., M.B., B.C. Cantab., of a daughter.

Marriages.

PENROSE — MILLS. — On September 23rd, at St. Mary's, Stoke Newington, by the Rev. Hamilton Rose, M.A., Arthur Wellesley Penrose, M.R.C.S. Eng., L.R.C.S. Lond., L.D.S. Eng., son of Arthur P. Penrose, L.D.S., of 33, Compton Terrace, Highbury, to Mabel Gertrude, daughter of B. J. B. Mills, of 48, Highbury New Park, late of 54, Tollington Park.

STEWART — DANIELL. — On September 6th, at Detling Parish Church, by the Rev. E. F. Staines Daniell (brother of the bride), assisted by the Rev. E. F. H. Thomas (cousin of the bride), and the Rev. H. H. Letchworth, Vicar of the Parish, Walter Grahame Stewart, M.B., B.S. Lond., M.R.C.S. Eng., L.R.C.P. Lond., youngest son of the late Robert Stewart, of Port Elizabeth, South Africa, to Rebecca, eldest daughter of Major-General F. F. Daniell, late 1st Battalion Gordon Highlanders, of Hillfield, Detling, Maidstone.

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription (see Clubs' Union Blue Book, p. 17) to the Clubs' Union, any student of the hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park Station, on the London, Brighton and South Coast Railway, and to the Crofton Park Station on the South Eastern and Chatham Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

The ground-man, who is a professional cricketer, has quarters in the pavilion. His duties are to keep the ground in order, to prepare the wickets and lawn tennis courts, and to bowl to such members of the Union as shall be selected by the committee of the Cricket Club. Lockers may be rented on application to the ground-man, at a charge of 5s. for the summer or 2s. 6d. for the winter season, 2s. 6d. deposit is also required on the key.

Cheap railway tickets between London Bridge and Honor Oak Park stations are issued to members of the Union upon conditions which will be found enumerated in the Clubs' Union Blue Book.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, Water Polo, and Bicycle, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues. Blues and Half-Blues are awarded for Athletics, dependent on the recommendation of the Athletic Committee according to the performances at the Inter-Hospital Sports, while there are allotted to the Lawn Tennis three Blues and three Half-Blues, to the Water Polo seven Half-Blues, and to the Bicycles six Half-Blues.

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUBS.—President, W. H. A. Jacobson, M.Ch. Rugby—Captain, A. B. O'Brien; Hon. Sec., A. E. Harrison; Captain Second XV., H. S. Brown; Captain Third XV., H. D. Smart; Captain Fourth XV., T. Norman; and a committee of five, one representing each year. Association—Captain, H. Barber; Hon. Sec., E. L. Norton; Captain Second XI., P. A. Peall; Captain Third XI., H. A. Watney; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over fifty years, the season 1902–3 being the fifty-ninth. Very little is known about its early history. It is, however, recorded that when the Rugby Union was formed in 1871, the G.H.F.C. was one of the original pioneers, and the only hospital club in the movement; it then had a reputation second to none. The club's position in the football world was acknowledged by the Union electing J. H. Ewart to serve on its first committee, which included such historic names as A. Rutter (president), E. H. Ash (hon. secretary), F. J. Currey, F. Stokes and A. G. Guillemard. Amongst the many brilliant players who at one time or another have appeared for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (captain 1877–8), A. S. Taylor, W. G. Mitchell, A. Allport, H. W. Dudgeon (England); H. M. Jordan (Wales); R. Evans (Scotland); F. O. Stoker (Ireland); and E. Morgan (Wales).

In 1874 the Inter-Hospital Challenge Cup was instituted, which Guy's was fortunate enough to secure for the first time. Since its institution, St. Thomas's has held the Cup ten times; Guy's seven times; St. George's three times; London and St. Bartholomew's twice each; and Middlesex and St. Mary's once each.

In 1891, Guy's, Middlesex and St. Thomas's were left in, the ties not being played out.

Last year, after most brilliant displays in the Inter-Hospital matches, we retained possession of the cup; and from the present aspect of affairs there is no reason why we should not keep our prestige in this coming season, if only men will evince the same keenness which they showed during the past year. The plea of lack of time cannot possibly be entertained, for continuous and good training need cost little more than half an hour a day. The ground is always open, and footballs can always be obtained from Harris, the ground-man. The Gymnasium, too, must not be forgotten as a useful adjunct to getting fit. We have four fixture lists arranged this season, and we propose to hold trial games at the beginning of the season, the first being fixed for September 27th. The form shown at these games will be considered by the committee in choosing representatives in future matches, so it is particularly desirable that all freshmen should make a point of turning out.

For the benefit of freshmen in particular, we may state that lists will be put up in the smoking-room and

elsewhere, on which intending players should place their names as early as possible.

The officers of the club will be at all times very glad to give any information in their power.

The Association Football Club began its career in 1882, and has been carried on with much success since that time. In 1886 the Inter-Hospital Challenge Cup came into existence, and was won by Guy's for the first four years after its institution; during these years the Hospital twice won the Surrey County Challenge Cup. In 1894 and 1897 we again held the Inter-Hospital Cup, making in all six times. Reviewing last season, it may be said to have been pretty successful, despite the fact that in the final of the Inter-Hospital Cup, to which we have played our way for the past two years, we were defeated, and in the Surrey Cup our life was a short one. Most of last year's team are available for this year, and a good season is anticipated. The second eleven had an eminently successful season and played regularly throughout, doing well in the Surrey Junior Ties and winning the Inter-Hospital Junior Cup for the second time in the course of its brief existence. The third eleven played frequently, too. On October 4th and 8th trial games at Honor Oak Park have been arranged, more especially for the benefit of freshmen, and it is hoped that no freshman interested in "soccer" will hesitate for any reason to avail himself of this opportunity of proving his worth on the field, for it is largely on the result of these games that his inclusion in the teams later depends. Notices of the trial games will be duly posted in the Smoking Room of the College.

The following are next season's fixtures:—

FIRST ELEVEN.

Oct.	4	Trial game	Home
	8	Trial game	Home
	15	R.M.A.	Away
	18	Guildford	Away
Nov.	1	Surbiton Hill	Home
	8	Ipswich Town	Away
	12	Felsted	Away
	15	Weybridge	Away
	22	Eversleigh	Home
	26	Hastings	Away
	29	Beckenham	Away
Dec.	3	Godalming	Away
	6	Cheshunt	Away
	10	Wellingboro' G. S.	Away
	13	Tunbridge Wells	Away
	20	South Eastern College	Home
1903.			
Jan.	3	Old Reptonians	Home
	10	Ewell	Away
	14	Eastbourne	Away
	17	Beckenham	Home
	21	Old Carthusians	Home
	24	Weybridge	Away
	28	Casuals	Home
	31	Cheshunt	Home
Feb.	7	Ewell	Home
	14	Reigate Priory	Away
	18	R.I.E.C.	Away
	28	Surbiton Hill	Away
Mar.	7	Reigate	Away
	21	West Norwood	Away

SECOND ELEVEN.

Oct.	4	Trial game	Home
	8	Trial game	Home
	11	Woodford Albion	Away
	18	Old Foresters 2nd XI.	Away
	25	Weybridge 2nd XI.	Away
Nov.	1	Hampstead 2nd XI.	Away
	8	Parthians	Home
	15	Surbiton Hill 2nd XI.	Away
	22	Reigate 2nd XI.	Away
	26	Leavesden Asylum	Away
	29	Beckenham 2nd XI.	Home
Dec.	3	Sevenoaks School	Away
	6	Cheshunt 2nd XI.	Home
	13	Central Technical College	Home
	20	Parthians	Away
1903.			
Jan.	3	Guildhall	Away
	10	Ewell 2nd XI.	Home
	17	Beckenham 2nd XI.	Away
	24	Woodford Albion	Home
	31	Cheshunt 2nd XI.	Away
Feb.	7	Ewell 2nd XI.	Away
	14	Surbiton Hill 2nd XI.	Home
	21	Hampstead 2nd XI.	Home
	28	Old Foresters 2nd XI.	Home
Mar.	7	Clapham Rovers 2nd XI.	Away
	14	Central Technical College	Away
	21	Carshalton Park	Away

THE CRICKET CLUB.—President: W. A. Brailey, Esq., M.D. Captain: H. Barber. Vice-Captain: H. D. Wyatt. Hon. Secretary: H. D. Wyatt. Captain 2nd XI.: F. W. Strange. Captain 3rd XI.: G. N. Bartlett, and a committee of five.

Guy's have the best cricket ground of any London hospital and generally turn out a good cricket team.

Since the institution of the Hospital Cup in 1882, we have won it on twelve occasions. The Cup was lost this season, Middlesex beating Guy's in the second round of the Cup tie.

To the list of successes achieved in Cup-ties which is usually published in this paragraph, we add four "centuries," and two good bowling performances from last season's competition.

Three-figure innings in Cup-ties: J. C. Shenton, W. J. Scott, F. Colclough, J. H. Joyce, W. I. Hancock, C. J. Francis, F. C. Wetherell, H. M. Langdale, G. S. Graham-Smith, M. C. Wetherell, H. Barber.

In bowling, C. H. Reigate and J. D. Cruikshank took all the King's wickets in 1886 for *three* runs; J. H. Bettington seven for 21 against Bart.'s in 1890, and W. G.

Mitchell the same against St. Mary's in 1887; J. H. Joyce, in 1893, took twelve for 36 against King's, and eight for 19 against Westminster; F. C. Wetherell took five of University's wickets for 15 in 1897. In 1901, C. M. L. Cowper and M. C. Wetherell shared the wickets in dismissing Westminster for 18 runs, and R. C. Poyser took seven Bart.'s wickets for 18 in the second innings of the final tie.

In conclusion, we should like to add that our prospects for the immediate future are fairly hopeful, and that though the Cup-ties lend themselves better to records, we do not wish to give them undue prominence, as perhaps many of our ordinary time-honoured fixtures are the more enjoyable matches.

THE ATHLETIC CLUB.—President: R. Clement Lucas, Esq., B.S., F.R.C.S. Hon. Secretaries and Treasurers: E. M. Harrison and J. S. Hodgson; and a committee of eleven. The annual meeting of the Athletic Club is held in June at the Clubs' Union Ground, Honor Oak Park. From amongst the successful competitors, the team to do battle for Guy's at the United Hospitals meeting is selected. Since the institution, in 1867, of the Athletic Championship of the United Hospitals—the first inter-hospital competition of any kind—Guy's, who were the first to secure the shield, have won it on eight occasions, St. Bartholomew's twelve times, St. Thomas's five times, St. Mary's four times, King's and St. George's three times each, and London once. Among the prominent athletes who have performed for Guy's are:—W. Malby, who appeared for North v. South in the two miles during 1873; A. W. Pearson, J. Reader, J. G. Gravely (1877), hurdles, who held the record for some years; L. Stokes, A. S. Taylor, W. G. Mitchell, H. A. Munro, who for five years (1891–95) won the mile and three miles, in each of which he holds hospital record, and in 1895 he won the amateur championship for four miles; H. T. S. Bell, who has three times (1892–94) won the 100 yards, twice (1892–3) each the 220 yards and high jump and long jump (1893–4); in his last year he also tied for first place in the "high"; P. R. Lowe, hurdles (1892–93); F. S. Batchelor, 440 yards (1893); E. N. Scott, throwing the hammer (1893–94–95), and F. W. Sime, 100 yards (1898), and 220 yards (1898–99).

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, M.S., F.R.C.S. Captain: E. N. Jupp. Hon. Secretary and Treasurer: B. A. Wedd; and a committee of eight. The club has been in existence some nine years. There are sixteen very good grass courts at Honor Oak, which are open for play from the end of April to the end of September. The club holds, at the beginning of the season, several trial games, which serve to bring before the notice of the committee all promising new players, while one or two matches are played weekly against various London clubs. The Inter-Hospital Challenge Cup was instituted in Jubilee year; it was held by St. George's until 1890; Guy's held it in 1891–1892; St. Thomas's, 1893–1896; St. Bartholomew's, 1897; London, 1898; St. Bartholomew's, 1899 and 1900. In 1901 and 1902 it was won by St. Thomas's. A cup was also presented in 1899 by the late Dr. Washbourn, for a competition for second teams, which has been won this year by St. Thomas's.

THE RIFLE ASSOCIATION.—President: L. A. Dunn, M.S., F.R.C.S. Vice-Presidents: G. Newton Pitt, M.D., A. P. Beddard, M.D., E. J. Spriggs, M.D. Captain: O. B. Travers. Hon. Secretary and Treasurer: R. Felton; and a committee of five.

The Association arranges matches with the sister hospitals of London and with public school cadet corps, and also enters a team to compete for the United Hospitals Challenge Cup at Bisley during the "week," Both civilians and volunteers are now allowed to compete in the United Hospital Competitions and in the Bisley Cup; but there are numerous advantages attendant on a membership of a Volunteer Corps, and the honorary secretary of the Association will readily give any information required with regard to suitable corps.

The Annual Prize Meeting and the Newton Pitt Challenge Cup Competition are held in July, before the close of the session. Due notice of these and all other events will be posted on the notice board in the Colonnade.

It is earnestly requested that each and every man interested in shooting will communicate early with the Secretary, so that the Committee may have some idea of the number of men for whom they have to arrange next season's programme.

The Annual General Meeting will be held early in October (notice of exact date will be posted conspicuously) and it is hoped there will be a good attendance.

ARTISTS R.V.—Numbers of men entering the hospital, and especially those coming from public schools, are anxious to take up, or keep up, Volunteering as a hobby.

While there is no need to point out to any sensible freshman the need of a hobby of some kind in hospital life, veterans will assure them that Volunteering is a privileged hobby which none will regret having taken up.

Of the numerous London rifle volunteer corps, the Artists (20th Middlesex) has at present the strongest hold on Guy's men, as it had in the past. At one time G Company was composed exclusively of Guy's men, and during the recent enthusiastic recruiting movement, a section of this company was still reserved for them. There is no reason why this exclusive section should not be kept up if the keen men would only come forward more readily instead of waiting to be pressed into service.

All particulars will gladly be supplied on application to Lce.-Cpl. R. Felton, or any other Artist at the hospital. Men should come forward early in order to complete their recruit drills in good time.

Late members of public school Cadet Corps are reminded that the new regulations will not exempt them from recruit drills if they have allowed a year of non-efficiency to elapse.

THE BICYCLE CLUB.—President: C. H. Golding-Bird, F.R.C.S. Captain: A. H. Forbes. Vice-Captain: S. J. Saunders. Hon. Secretary and Treasurer: G. F. Hardy, and a committee of six.

The Club meets for runs every Saturday, except when engaged in race meetings, of which there are four every year, in addition to hospital contests.

A general meeting for the election of officers, etc., will take place in November, and all students who are cyclists are requested to communicate with the Hon. Secretary, or any member of the Committee, and thus obtain full particulars.

The object of the club is to promote social runs among the members. In addition to several valuable prizes for competition, the President has given a very valuable cup to be raced for annually by members, the winner holding the championship for the season. The Captain is the present champion. It is hoped that all speed men will make themselves known, so as to be of service during the coming season.

The hospital has been represented in the United Hospitals, Cambridge, Oxford, London B.C., and Sheen House matches.

GUY'S HOSPITAL SWIMMING CLUB.—WATER POLO.—President: A. D. Fripp, Esq., M.S. Vice-Presidents: L. A. Dunn, Esq., M.S., J. Fawcett, Esq., M.D. Captain: H. Bacon. Vice-Captain: A. L. Moon. Hon. Sec. and Treasurer: R. B. Dawson. Committee: L. V. Ransford, J. Cameron, C. H. Reinhold, R. Franklin, H. M. Grose.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S. Hon. Secretaries: G. Bellingham Smith, B.S., and A. P. Beddard, M.D.

This flourishing society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital. From a copy of the old laws of the Physical Society, dated 1800, we learn that the Society met every Saturday night, from seven to ten, during the month of October, and each month until the following May. Business at these meetings was divided into private, including "matters in which the Society may be concerned," and public, consisting "in the communication of cases and opinions." A fine of sixpence was exacted from a member absent at the "Roll Calls," also from a member refusing to "hold up his hand on one side or the other," to decide any question. Members were divided into honorary, ordinary and corresponding. So much for the old Physical Society, of which an account is given in the *Biographical History of Guy's Hospital*, by Bettany and Wilks, a work which every Guy's man should possess. It may be obtained from the librarian, who has still some copies of the first edition, price 10s. 6d.

At the Pupils' Physical Society, which meets on Wednesday evenings each fortnight, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion.

"Clinical and Pathological Evenings" are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member.

Members are reminded that in connection with the Society the following prizes are offered for competition:—The Treasurer's Prize of £5 is given annually, and the subject of the Essay for the ensuing session will be announced later. The Society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 46).

THE DENTAL SOCIETY.—President: P. S. Campkin, L.D.S. Vice-Presidents: M. F. Hopson, L.D.S.; R. P. Rowlands, F.R.C.S.; J. Lewin Payne, L.R.C.S., L.R.C.P., L.D.S.; Hon. Secretary and Treasurer: A. D. Crofts. Committee: J. E. Spiller, L.D.S., H. P. Aubrey, H. E. Collett, S. A. Piper, H. S. Snowden.

The Society was founded in the early part of 1894. Its eighth session commenced in October last, and was eminently successful in every way; good papers were read and much interest was taken in the meetings by the members.

Meetings are held every month during the winter session. They are held in the Dental Lecture-room on the second Friday in each month, at 4 p.m. Papers on subjects of dental interest are read, after which a discussion takes place; clinical cases are also shown at each meeting; and one evening during the session is specially set apart as a clinical evening. This year a prize of £5 will be given for the best paper read before the Society. The first meeting will take place on October 10th, at 4 o'clock p.m.

THE DEBATING SOCIETY.—President: G. H. Savage, M.D., F.R.C.P. Vice-Presidents: J. Fawcett, M.D., A. W. Ormond, F.R.C.S., and E. I. Spriggs, M.D. Hon. Secretaries: R. Edridge, E. H. Griffin; and a Committee of six students.

The Debating Society is entering on its eleventh year of existence, and its ninth as a constituent of the Clubs' Union.

Five meetings are usually held in rotation with those of the Physical Society and the Smoking Concerts. Any subject except theology may be debated. Private business is allowed. A "Ladies' Night" is held at the end of the Session, at which members bring their friends, who are eligible to speak.

The secretaries, or any member of the committee, are always happy to receive suggestions or notices of motions to be brought forward at the meetings. Except at

"impromptu" debates no one is called upon to speak. The society has been exceedingly flourishing during the last three years.

THE GUY'S HOSPITAL GAZETTE is published on alternate Saturdays, from the library of the hospital, where copies may be obtained by all members of the Clubs' Union and by immediate subscribers.

Established in 1872, the GAZETTE was the first Journal of its kind ever published in this country. It ran an uninterrupted course until November, 1879, and was then suppressed by the hospital authorities rather from excess of zeal than from lack of material The present "new series" was inagurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication, and only had a small circulation in the hospital itself. Its circulation now practically includes all Guy's men throughout the world, as well as the Nursing Staff, past and present.

The management of the GAZETTE is vested in a committee constituted as follows. Three members of the Hospital or School Staff, *appointed yearly* by a School Meeting. Two students, appointed yearly by the Clubs' Union Council. The President of the Residents for the time being. An Editor appointed by the Committee. A Manager appointed by the Committee, and other students not less than four in number and not more than six co-opted by the Committee.

The columns of the GAZETTE are open to contributions and correspondence from all sources, the writer's name being requisite as a guarantee of good faith, if not for publication. All contributions must be deposited in the editor's box in the colonnade, or addressed to the editor by post not later than Wednesday in each week of issue.

THE REPORTS.—Edited by J. H. Bryant, M.D., and F. J. Steward, M.S.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are published periodically, and contain contributions upon professional and scientific subjects from the staff of the Hospital and Medical School.

THE STUDENTS' CLUB.—Committee till 1903 (March). President: P. H. Pye-Smith, M.D., F.R.S. Treasurer: W. Hale-White, M.D. Hon. Secretary: A. W. Ormond, F.R.C.S. Hon. Assistant Secretary: R. H. J. Swan, and a committee of eight.

The above-named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book, p. 53.

GYMNASIUM.

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice, and during the winter session the boxing instructor attends on Thursdays from 4 to 6 p.m., and the gymnastic and fencing instructor at the same time on Tuesdays. At the end of the session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given on the "Ladies' Night."

In Lighter Vein.

CENTRAL CRIMINAL COURT.

BEFORE HIS HONOUR JUDGE PRESTIGE.

THE "Medical Committee, Limited," were charged under the Companies' Act with conspiracy and wilful mismanagement.

The prisoners, who were accommodated with seats in the dock, presented a shabby and faded appearance. They included Lord Erehole (chairman of the Board of Directors), Mr. Tension Tosh, Dr. Phosphate, Jostling John, Simons the Cellarer, Prof. Andreoletti and Dr. P. Winkle.

As so often happens in these *causes celèbres*, the court was crowded with the riff-raff of Bermondsey.

Just before proceedings commenced, a top hat was observed to hurriedly enter and take a seat in the well of the court.

Mr. Muffin Tartlett, K.C., in opening the prosecution, said that this was a very painful case. He was sorry to say that all the prisoners had been previously convicted for similar offences. The fact that most of the prisoners could not distinguish four ale from bottled Bass was in itself a suspicious circumstance. The jury must know that it was impossible to make a silk purse out of a soused mackerel, and he would, therefore, call the first witness for the prosecution.

Mr. Burner, temporary deputy additional assistant's assistant, etc., was then called. In reply to a question by his Honour, he said that he had got his hat at the exhibition of '51, and had worn it ever since, and please God he'd be buried in it.

Cross-examined by Mr. Blodgers (for the defence), he said that he would take his oath it was a hat. Counsel said that the evidence of a man who had sunk low enough to make such a statement was worthless. Witness was, therefore, dismissed without a character.

The Commissionaire said that he had never received a sixpence from any of the accused, and that he always thought they would come to no good.

At this stage some commotion was caused in court by the prisoner Tosh attempting suicide with a strabismus hook. With the assistance of Bashful Bill, the carpenter, prisoner was wired to the dock and the case resumed.

Mr. X. Rays was next called, but the judge refused to accept his evidence unless he had his hair cut.

Mr. Muffin Tartlett said that, as it was such thirsty weather, this would conclude the case for the prosecution.

Mr. Blodgers (for the defence) said that it was a disgraceful thing that men of such beautiful lives—men whose singleness of purpose and integrity of heart were byproducts (applause)—should, etc., etc. He asked the court to look at the accused.

* * * * * * *

After the dead and dying had been attended to, resuming, counsel called the Lord Warden of the Stink Pots, who said that for seven years it had been his proud privilege to act as valet to Dr. P. Winkle. Further, he was an eye surgeon and———. At this point the judge cautioned the witness, reminding him that he was on his oath.

Bugler Brailey, of the Boys' Brigade, said that he held an important official position in the hospital, and then, turning towards the dock, in a sobbing voice said that he would not pluck out dad's eyes—those eyes that never had nor never would so much as frown on him (sensation).

Mr. Horace Cuddler admitted that the socks (produced) were his, but denied that any offence was intended.

Cross-examined, he said that he did not practice on the Margate sands.

Mr. Shodgson, from West Africa, a coloured gentleman, stated that he thought it was the fairest list he had ever seen. For this piece of information he was given six months, without the option, for contempt.

Mr. Blodgers then threw up the case.

Mr. Muffin Tartlett (who on rising was heard to murmur softly to himself, "Royal Horse Artillery") said he did not think it necessary to cross-examine the judge, and would, therefore, ask his Honour to pass sentence.

His Honour said that before passing anything he would advise that more care be taken in drawing the names from the hat.

The prisoners would be confined at Bethlem.

THE BIRD OF PREY.

A Rare Form of Contracted Pelvis: Difficult Cephalotripsy: Recovery.

E. N., æt. 25, single, primip., was admitted into Victoria at 10.30 p.m. on September 5th, having been in labour eight and a half hours.

History.—Amenorrhœa since November, 1901. Labour pains began at 2 p.m. on Friday, September 5th. At 8.30 she was seen by a doctor who recommended admission to hospital. The os then admitted two fingers, vertex presentation. The membranes had ruptured but it was doubtful when this had occurred.

On examination.—Patient was a small woman (height 4ft. 2in.) and there was well marked kyphosis in the lower lumbar region, due, according to patient, to a fall in infancy. There was no curvature of the limbs nor any sign of tubercular disease anywhere. Over the legs and arms and lower abdomen there was an urticarial rash which showed signs of having been much scratched. There was also œdema of the legs, lower part of abdomen, and conjunctiva. A very noticeable feature of the abdominal tumour as the patient was lying on her back, was the prominence, which was very marked. The belly was pendulous. This appearance gave the impression that the fœtal head could not have been engaged in the pelvic brim at all. This was confirmed by palpation for the uterus could be freely moved from side to side, and the fœtal head was felt just above the brim. Fœtal limbs were felt to right, but no movements were detected. Fœtal heart not heard anywhere. On vaginal examination the vulva was not œdematous, but the vagina was found to be very small. The os admitted the tips of four fingers, membranes were ruptured, and the head was lying across the brim, the occiput being to the left.

Measurements of pelvis:—

Interspinous	...	...	...	9¼ inches
Intercristal	...	...	...	10 "
External conjugate	...	...	...	6¾ "
Transverse at outlet	...	...	...	2¼ "
Antero-posterior at outlet			...	3¼ "

Diagonal conjugate could not be measured as the promontory was out of reach.

The general condition of the patient was good though the short ineffectual pains were beginning to exhaust her. Pulse 90°. Urine normal.

Diagnosis.—Funnel-shaped pelvis with some general contraction was diagnosed. The patient was extremely sensitive and a satisfactory examination could not be made without an anæsthetic, so A.C.E. was given which she took very badly. The internal measurements given above were then determined. It was evident from these

measurements that delivery could only be effected by Cæsarian section or cephalotripsy. The points against Cæsarian Section were :—1. The urticarial rash on and the œdema of the abdominal wall. 2. There was no evidence of the life of the fœtus, movements and heart-sounds being absent. 3. The uterus was becoming moulded to the fœtus. 4. The patient was deformed and unmarried. Cephalotripsy was therefore decided on, though considerable difficulty was anticipated.

A.C.E, was given to the full extent. A catheter was passed and a copious vaginal douche given. Perforation was effected through the right parietal bone rather far back and the brain matter broken up and allowed to escape. The cephalotribe was then applied and the head crushed, but owing to the small size of the pelvis it was very difficult to apply the upper blade, the guiding hand and the blade itself leaving very little room for manipulation. The head being so movable above the brim increased the difficulty, as it receded when any attempt was made to seize it. The crushing at the first attempt did not diminish the size of the head very much so it was gripped in a small diameter. Traction was made and the cephalalotribe was re-applied, this time over a larger diameter. Traction was made again for some minutes, but with little advance. It was now determined to turn and bring down a leg. The hand was slowly introduced into the vagina and the head found to be movable above the brim. The right leg, after a great deal of trouble, due to commencing retraction ring, and loss of liquor amnii was brought down. After traction on this leg, combined with rotation for some time, an attempt was made to bring down the left leg, but this failed, although some progress was made. The cephalotribe was applied to the half breech and powerful traction made with good progress. It was now possible to reach the left groin and the blunt hook was passed into the pelvis, but could not be manipulated. Tedious digital traction brought down the left leg after a time. The trunk descended without much difficulty. The arms were next brought down by pressure being made on the point of the shoulder combined with rotation of the trunk of the fœtus. The head being still arrested at the outlet owing to the imperfect crushing, it was perforated again, this time through the occiput, the body of the fœtus being meanwhile held well back on the perineum. The cephalotribe was re-applied, one blade into the perforation and the other on the opposite side of the head and the base was crushed. Delivery was then effected pretty easily.

This operation took almost three hours, but in spite of this there was little post-partum hæmorrhage. The placenta was detached and a hot intra-uterine douch given. There was a good deal of bruising of the vagina, and the perineum was ruptured as far as the anus. After thorough cleansing of the parts several sutures were put in and the patient put to bed.

The fœtus was a well-made male weighing 6½lbs. Subsequently the patient developed a good deal of bronchitis and the temperature kept up for a day or two, but she is now making a good recovery. R. S. R.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Hereafter.

DEAR SIR,—I have the whole of this interesting correspondence on my desk as I write. The pin that "Spero" drives into the "New boys" is material, but very practical. "The folk want to be cured and quickly too, and there are many ready to do it for them," therefore, learn all you can or you will be left behind in the race.

In my last letter I asked "R. H. F." to state how his "Mutual Aid Association" should have governed "Spero's" action in three cases. "M." has taken up the cudgels. What does he mean by "smart" diagnosis? Certainly none of "Spero's" work deserves such a description. "Noising abroad" is beautiful English, but irrelevant to the matter in hand as it is safe to assume that "Spero" is above such a method of blatant advertisement. I maintain that there is no excuse for a man not finding a lesion in a patient for want of looking, and that it is as wrong to shield such mistakes as it is to make verbal comment on them.

"Excelling" was used in a far wider sense than "M" has the imagination to conceive. The excelling of the high standard set by the best men, not that obtained by one's immediate "opposition." I have quoted "Spero's" letter with approval. He speaks of mixed motives. It is admitted that all our actions are complex. To no part of "Spero's" letter do I give more firm adherence than to the last sentences. If "M" will take the touble to read my last letter with care he will observe that "the curiously altruistic consideration" could only refer to the relations existing between medical men. The meaning he has put into the sentence is manifestly absurd.—Yours truly, P. G.

The Bermondsey Settlement.

DEAR SIR,—Will you allow me to state in your columns that we have vacancies for several residents at this Settlement. We are within easy reach of Guy's Hospital, our buildings are well appointed, and residence in the Settlement affords valuable experience in many ways to those who are entering the medical profession.

I shall be very glad to correspond with anyone who may desire further information as to our tariff and conditions.—Believe me, dear sir, yours faithfully,

J. SCOTT LIDGETT, Warden.

Guy's Hospital Physiological Society.

DEAR SIR, — Will you kindly announce that this Society holds meetings during the session on alternate Thursdays, at 4 p.m., in the Physiological Buildings. Papers on Physiology and allied subjects are read by

members. The Annual General Meeting will be held early in October, of which due notice will be given.—

Yours, etc. M. de L. ROBINSON,
20th September, 1902. Hon. Sec.

Rugby Football.

DEAR SIR,—In accordance with the usual custom, I beg to draw the attention of all Guy's men—Freshmen and others—to the fact that the Rugby Football season is about to begin, and it is necessary to begin training at once if we wish to maintain the high standard of our football in previous years.

In past seasons we have always done well. It is only necessary to mention that the Cup is at present in our possession, and it is the duty of every man to see that the Cup remains with us again this season.

We have very good fixture lists for all our teams, and there is ample opportunity for men to get into good form, so that if men fail to have good football the fault is entirely their own.

It is to be hoped that all our old players will enter on the coming season with renewed vigour and that freshmen now entering the hospital will soon acquire the necessary esprit de corps which characterises Guy's men, and all set to work with a will to rival and excel if possible past performances.

All new men wishing to play will find a list in the Smoking Room, where they may enter their names, or they may communicate either with the secretary, E. M. Harrison, or myself.

It is important that freshmen should play in the trial games, as it is only in these that the committee gets an opportunity of judging the merits of the various men.—

Yours etc., A. B. O'BRIEN, Captain.

Association Football.

DEAR SIR,—Will you kindly permit me through the medium of the GAZETTE to make a few remarks in connection with Association Football, seeing that another season is close at hand. In the first instance, to those interested in the game who have just entered the hospital, and may they be many, the trial games to be played at Honor Oak Park on October 4th and 8th have a special significance, and it is hoped that all such freshmen will play in them. Secondly, the advice, well-worn perhaps but not less forcible, to keep in a fit state of training throughout the season, applies to all, and the easily accessible ground at Honor Oak Park affords every opportunity for attaining this. Last season the first eleven reached the final for the Inter-Hospital Cup, and the second won the Junior Cup; both teams have entered for the Surrey Senior and Junior Cups respectively; the Inter-Hospital ties begin after Christmas, and it goes without saying that the goal of our ambition is to bring the Senior Cup back to Guy's and keep the Junior, results which cannot be attained without keen training and the display of persistent and hard endeavour on the field. Lists of the teams selected to play in the matches will be posted in the Colonnade as early in each week as possible to enable men who are compelled to scratch to do so early, thereby giving the Committee sufficient time to choose substitutes. Trusting that all will combine to make the season very successful and thanking you in anticipation for the insertion of this letter,—I am, yours very truly, E. L. NORTON, Captain.

Guy's Hospital, Sept. 21st, 1902.

Appointments.

DEAR MR. EDITOR,—May I offer a suggestion which is, I believe, not original, but which seems to me to be worth a repetition. It is that in future selections for house appointments, voting papers should be sent out a week previous to the date of meeting, in order that those who are unable to attend may still be able to record their votes.

The results of these meetings are of very vital importance to candidates, and it would be well if the theoretical excellence of our system of selection could be carried into practice. That the system not infrequently fails at present is, I imagine, sufficiently obvious to everyone, and the easiest and most comfortable explanation is that sufficient members to make the meeting thoroughly representative find themselves unable to attend.—Yours faithfully,

ARTHUR PEARSON.

From an Institution Nurse's Letters.

Uganda Railway, Nairobi,
British East Africa,
June 26th, 1902.

We get Reuter's telegrams every day, and are anxiously waiting for later news of the King than 11 p.m. on Tuesday.

Nairobi is quite a new place. It stands very high up among the hills, so that it is quite cool here. The temperature in the summer seldom goes higher than 80° in the shade, and just now it varies from 60° to 75° The nights are rather cold, and we have had a fire going in the evenings, but with that one must have the windows open. The houses are built bungalow fashion. All the heads of departments live up here on the top of the hill, or rather on the slope. Down below, on a plain that stretches away for twenty miles, the bungalows of the subordinates are built. There are about a hundred and fifty of them, in rows of twenty-two each, all alike Then comes the station with immense workshops. Then the Coolie hospital, with such stores; just fancy getting in quinine by the *ton*. Mr. —— took me all over it one day. The hospital is *not* like Guy's. Away from the bungalows are the huts of the native bazaars. On the plain are thousands of different kinds of wild animals, chiefly zebra and wildebeeste. The hyænas make a great

noise at night quite close to the houses. The lions also come out at night on the plains, to try to get some of the zebra. There are no man-eaters about just now, and unless the lions are wounded, they run away. There is a man here, who came out to shoot big game, who wounded a lion. It knocked him down twice but he got up again each time. Then the lion got hold of his left arm, and while he was gnawing at it Mr. —— shot the lion with the other arm. His arm was dreadfully mauled, and he was in hospital for some time, but is now better and able to be out, and anxious to be shooting again.

All the servants are men, chiefly Swahili from the coast. They wear indoors a long white garment called a *kanza*, no shoes or socks, and always a fez on their heads, either white or red. It seems so funny to have one's early cup of tea brought in by a black man. The cook and butler are Goanese. The natives about here are Masai, who are of very little use as workers. I wish you could see some of them. They are dreadful looking creatures, with very little dress, mostly with clean shaven heads, and their ears frightfully deformed with great heavy hanging things. I have seen a jam pot sticking in a man's ear; arms and legs covered with steel ornaments which are never removed, and great hoops of steel beads round their necks. I so regret not having brought a kodak.

There is a lot of sleeping sickness in Uganda, and there was one case here, but before I came. The mosquitoes are not at all bad; there are a few, but by sleeping under a curtain you can quite avoid them, and escape fever.

Mombassa,
July 29th, 1902.

I am quite sorry to be leaving this week. I have seen everything under the best conditions, and they have been so kind to me. Last Friday they took me up as far as Naivasha. We could not go right up to Lake Nyanza, as I did not like leaving my patient for so long. We had just the special engine and inspection carriage, which contains sitting room, bedroom, kitchen, and everything necessary. We started at 9 a.m., and had breakfast in the train. The butler and two other servants went with us, so everything was well done. Naivasha is about seventy-six miles up towards the lake, and through some of the most lovely scenery it is possible to imagine. We rode on the cow-catcher, and it was just glorious to rush along in front of the engine, so well could we see the country. Presently we came through a forest and jungle, and saw six great baboons. I thought they were bears at first. Then we came to the escarpment. We had been going uphill all this time from Nairobi, which is close on 6,000 feet above sea level, to the highest point in the railway, 8,800 feet. Then came the great drop down into the Great Rift. This has been the most difficult part of the line. The permanent line winds round and round in a sort of zigzag, through tremendous cuttings. We went rushing down the cuttings, but the temporary line used to go down very much steeper inclines, where no passengers except those at work on the line were allowed to go. We walked down the first incline, and looked down the other two, a sheer drop of 1,500 feet. It must have been most trying to the nerves. The whole line is a wonderful enterprise.

The Great Rift, or ditch, of Africa runs right through from a place in German Africa to the Red Sea, and is forty miles wide, with hills everywhere on each side. You want to see it all to appreciate its grandeur. Rushing through the cuttings you come to high hills in front, which look exactly like parts of Switzerland. After the Kikeya escarpment is past, and you fancy it is going to be all plain sailing, you come to eight miles of road over ravines and rivers. There are eight viaducts in the eight miles, some of them of immense height over the tops of tall trees. Then we got to Naivasha, where there is a most beautiful lake, about thirty miles in circumference. We went just a few miles further to see another bridge they are building. Beyond that is another escarpment where the railway climbs up again.

We had lunch and tea in the train. Once on the cow-catcher when we were going at forty miles an hour my hat flew away, and the train was stopped while a man went back to fetch it. It was quite cold, and we had to be wrapped up in rugs and thick capes.

The natives up there are not to be trusted. Mr. —— forgot until we were nearly half-way down the incline that it was necessary to be guarded. However, he said nothing to us till we were near home again. The natives have been known to kill people quite lately. Mr. —— said he would not take us into the native path for anything; as it was, in coming back we met half-a-dozen men armed with very shining spears and shields, evidently coming down to see what we were doing. They are a very wild tribe, and many of them are absolutely naked. You seem to take it as a matter of course out here; they are very black and dirty, and seem much more like animals than men. They come in and stick their spears in the ground outside their huts in a very business like manner.

One Sunday hundreds of Masai warriors came into Nairobi, armed with long spears and shields, to ask leave from the Commissioner to go out and fight with another tribe. Of course this was not allowed. The Masai are very friendly, and look on the white people as their protectors, and call them their fathers and mothers. They are not a bad lot, though they drink the blood of live animals, and are altogether savage in their mode of living.

My pen has been running away, but I am leaving Africa to-morrow, and shall not write again, except perhaps from Naples. We hear that cholera is very bad in Egypt, so I suppose we shall not be allowed to land at Port Said this time.

ERRATA IN LAST ISSUE—

Page 356, line 29.—For nasal, read temporal.

Page 355, line 33.—For 2 per cent., read 5 per cent.

ED.—A. P.

Contents.

	PAGE
On Headaches and their Treatment: Clinical lecture by Dr. Pitt	405–410
Prize Day	410–415
South African Memorial Fund: 15th Subscription List	416
The Sanitas Electrical Company	416
Passim	417–419
Asphyxia and Death caused by a tooth in the Larynx while under Anæsthetic	419–420
My Final	420
Diphtheria: its Cause and Cure	420–422
Correspondence: Guy's Hospital Debating Society; The Chapel Choir	422
From the Gazette's Special Pathologist	422
The Annual Students' Dinner	423–427
Notices	427
Pass List	427
Sport: Rugby Football—Guy's v. Kensington	428

Calendar of Coming Events.

Oct., 1902.

Sat. 11.—Messrs. Symonds and Steward's take-in; Drs., C. S. Morris and K. Black; Cl., F. H. Parker.
1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., Lennox, away.
II., Lennox II., home.
G.H.A.F.C., II., Woodford Albion, away.

Mon. 13.—1.15 p.m., Clinical lecture by Mr. Higgens.

Tues. 14.—Second Part Conjoint D.P.H. Exam. begins.
Final Conjoint Exam. begins.
1.30 p.m., Clinical lecture by Mr. Lucas.

Wed. 15.—G.H.R.F.C., I., Cambridge University, away.
G.H.A.F.C., I., R.M.A., away.

Thur. 16.—Messrs. Lucas and Lane's take-in; Drs., H. Mann and C. D. Pye-Smith; Cl., O. W. Richards.
G.H.C.U., address by Rev. Cecil de Cartrel.

Sat. 18.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., Catford Bridge, home.
II., Wasps, away.
III., King's College Engineers, away.
G.H.A.F.C., I., Guildford, away.
II., Old Foresters II., away.

Mon. 20.—1.15 p.m., Clinical lecture by Dr. Galabin.

Tues. 21.—1.30 p.m., Clinical lecture by Mr. Lucas.

Wed. 22.—G.H.P.P.S., Clinical Meeting. F. G. Cross.

Thur. 23.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. Moyle and M. Bramley Taylor; Cl., M. Moiser.
G.H.C.U., address by Rev. J. C. Elliot, M.A.

Sat. 25.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., Rosslyn Park, away.
II., Surbiton, away.
III., Kensington III., home.
IV., Wasps IV., away.
G.H.A.F.C., I., Surrey Senior Cup, 1st round.
II., Weybridge II., away.

Guy's Hospital Gazette.

OCTOBER 11, 1902.

On Headaches and their Treatment.

CLINICAL LECTURE BY DR. PITT.

Gentlemen,—The subject that I propose to bring before you is the question of Headaches. It is a very large one, and it is quite impossible to attempt to deal with it fully in the time at our disposal, but there are certain leading features with regard to the question of diagnosis, and certain general principles of treatment which I can lay before you to-day.

The cases in the wards which have particularly brought up this question are—

(1) A case of mitral stenosis in a young woman. The chief complaint of the patient is of *headache*, more or less severe, sometimes very severe, which has lasted for a long time, and is constantly recurring. Heart disease is a not infrequent cause of headache.

(2) A girl, eighteen years old, who was admitted for persistent headache. She had been suffering for the past six months from headaches of increasing severity and persistency which are located in the occipital region. She has been treated at the Obstetrical Out-patient Department because she has never menstruated. The patient was sent on to Medical Out-patients and thence to the Eye Department, where it was noted that she had optic neuritis, a certain amount of vomiting, and was very unsteady in her gait. She has now been in, some fortnight or three weeks, and although perhaps the headache is not so severe, the difficulty of walking has greatly increased; she has much mental failure, and often hallucinations of sight and many delusions. She is probably suffering from a cerebral tumour; we are not quite certain as to the locality of the lesion, but possibly it may be in the cerebellum.

The next case is that of a man, aged thirty-seven, who was admitted five days ago for intense, most agonising headache, with a temperature which ran up to 105·6°. For about a month past, his manner has been altered, he has been irritable and easily enraged, and some

three weeks ago threw up his work without any reason. He was not seriously ill until ten days ago, when he was seized with pain in the left thigh, the abdomen and the back, and on the next day intense headache came on. On examining him there was no evidence of optic neuritis, of any paralysis or loss of sensation, and practically you may say there was no evidence of any organic disease. The question suggested itself, Was this a case of some local lesion, or was it a case of toxic headache? We are still not quite certain. The temperature has gone down and the headache is very much better. There was no discharge from his ear. He had a certain amount of ozæna. You may lay it down, as a rule, that it is comparatively rarely that headache is the only evidence of organic disease in the brain, almost invariably it is supplemented by some other symptoms. It is most probable that this will turn out to be a case of toxic headache, but we must wait a little longer before we can be certain. (He left the hospital ten days later, well, the toxic cause remaining obscure. It may have been influenza.)

The simplest way to discuss the question will be to divide up the headaches into a series of groups: (1) Those in which there is some local trouble which is the origin of the pain—(*a*) Extra- (*b*) Intra-cranial; (2) Those in which there is some cerebral vascular disturbance; (3) Those which are toxic; (4) Those which are nervous—by *nervous* I mean an unstable condition of nervous exhaustion and not of disease; (5) Those which are reflex. Probably we are not far wrong if we say that the great majority of headaches which are at all persistent are reflex (but this must not lead us to overlook organic brain trouble or toxæmia as possible causes), and a very large number of occasional headaches are toxic. It is also remarkable that a patient with a nervous or reflex headache, who may complain bitterly of the pain, will sleep well at night, while a headache due to organic disease often produces insomnia.

First, a headache may be due to local *organic disease*. Increased tension causes local pain. The skin of the face and forehead, and round the back of the head is tense, and hence any increase of fluid in the connective tissue due to inflammation, rapidly gives rise to pain. Mastoid disease, inflammation of the pericranium, cranial caries, suppuration or erysipelas in the forehead, or any inflammation in the gums lead to intense local pain on account of the tension. So also do nasal polypi, or an accumulation of fluid in the nasal sinuses. These lesions, especially diseases of the nose, ears and teeth, may cause pain in two ways—first, by local tension, and secondly, by reflex influence.

If tumour should occur within any portion of the skull, it is almost invariably painful. A tumour of the dura mater or of the meninges gives very great pain. It has been suggested by some writers, Dr. Mitchell Bruce amongst others, that one reason why a lesion of the dura mater is excessively painful is because the brain is not able to move over its surface, but is fixed down with adhesions; the condition being similar to what occurs in pleurisy. The brain is constantly varying in volume as its activity varies, and we can realise that if it becomes fixed at any point to the dura mater, the disturbance set up may be painful. At any rate, the pain that results when the meninges or the dura mater are inflamed is out of all proportion to the pain which results when the brain proper is affected.

While some lesions in the brain itself are painful, the amount of pain varies very much. Some tumours give rise to no pain, but in the majority pain is a prominent symptom; and sometimes a small tumour no larger than one inch across will, simply on account of increased intra-cranial pressure, give rise to intense pain. Whether the pain is purely a question of locality is uncertain. It is supposed by some that there is a special centre for pain in the optic thalamus. It is doubtful whether this is so; but it is certain that any tumour or lesion which affects the surface of the brain is likely to give rise to much more pain than one which is situated deeply; and a tumour which rapidly increases in size and develops pressure quickly, will give rise to very much more pain than one which develops slowly; and a tumour below the tentorium, sooner than one above it. So that probably the pain is largely determined by how

near the lesion is to the surface, and by how rapidly the change is going on.

Cerebral aneurysm, abscess, softening, concussion, and depressed fracture may all be causes of pain. It is difficult to say which of them gives rise to the most intense headaches. Some of the most intense headaches that you will come across will be cases of cerebral abscess. Whether this is because the meninges are generally also involved, I cannot say.

One of the immediate effects of heat apoplexy is headache, and these often persist for years afterwards. It is not quite clear in these cases whether there is any actual change in the brain, but it is quite certain that people, when once they have had sunstroke, are very liable afterwards to headaches.

The next group of cases I have put down as due to *changes in the vascularity of the brain.* We are still very ignorant with regard to many factors in the circulation of the brain. It was formerly believed that in epilepsy the brain was anæmic, whereas Professor Horsley's work has entirely exploded that idea, and many cases of epileptiform convulsions are associated with abnormal vascularity of the cortex.

It is probable that vascular disturbances in the brain produces headaches in two ways. An engorged condition of the brain; as in heart disease, or in any condition leading to retardation of the venous circulation as in bronchitis or asthma; may by the retention of waste products give rise to headache.

Drugs which produce rapid dilatation of the blood-vessels, such as nitro-glycerine, nitrite of amyl, or nitrite of soda, give rise to severe headaches in normal individuals.

On the other hand, if the patient is extremely anæmic, or the blood-pressure very low, the brain is ill-nourished and the defective nutrition gives rise to pain. Severe loss of blood will have the same effect. One of the most common symptoms of anæmia is headache; in fact, intense anæmia is very seldom present without headache. Increased intra-cranial pressure from a tumour or an abscess, also induces cerebral anæmia.

There is still much uncertainty about the whole question. If the arterial blood-pressure be increased experimentally, the amount of blood which flows from the cranium is found to be increased. It is immaterial, perhaps, how much blood remains inside the cranial cavity, the point of importance is at what rate the blood flows through. The rate at first increases with the pressure, but if you still further raise it, the flow again diminishes, owing to the increased pressure on the sinuses interfering with the escape of blood from the veins.

Better nutrition results from a normal pressure, than when it is either in excess or defect.

Then come the *toxic* cases, which form a very important group. One effect of alcohol, taken in excess, as is well known, is to produce intense headache; but alcohol can also produce headache by inducing chronic degenerative changes in the brain.

In many, opium and quinine constantly induce headache. Uræmia and chronic Bright's disease are causes of very severe headaches, and in obscure cases where the source of the headache is not obvious, you should always examine the urine. As a rule, these headaches are intermittent and they may be very intense.

Syphilis also acts in two ways. The toxic headache of secondary syphilis is sometimes very intense; later on headache may be due to definite syphilitic lesions which have developed in the brain, such as pachymeningitis or endarteritis, which produces softening.

Influenza gives rise to extremely severe headache. Some epidemics in erysipelas, enteric, scarlet fever, small-pox, malaria, pneumonia and other specific fevers give rise to very intense pain in the head.

Headaches due to typhoid fever are constantly coming before you. They may be so severe as practically to cause you to forget the possibility of enteric, and to look for some local cerebral lesion. In this connection there is one very valuable, practical fact which is worth remembering, and that is, you very rarely in typhoid fever, have delirium and headache present together at the same time. The headache is an early symptom; and the delirium develops at a later stage, when the disease is fully established and the patient has ceased to complain of headache.

Therefore, in any patient who is suffering from delirium with headache, you may almost exclude typhoid and are more likely to be dealing with meningitis. This is a very important point of diagnosis, and will very often set you right when otherwise you might have had some difficulty.

Gout, which is probably the same as defective renal excretion, plumbism, and occasionally diabetes are causes of headache.

The next is a very important and common cause, namely, indigestion. Nothing is more familiar to us than the occasional intense headache of indigestion. They may arise in various ways. First of all, a man may have eaten too large a meal, the stomach becomes over distended and the food tends to putrify instead of digesting. Or he may have eaten some unsuitable diet, such as some decomposing or too high food which, as it digests, gives rise to toxic bodies; these, when absorbed, give rise to severe headache. In many cases there may be a deficiency of gastric juice, and if so, 10 minims of diluted hydrochloric acid taken with food may suffice to prevent headaches.

Hepatic insufficiency. There is no doubt that the liver, besides its functions of storing up carbohydrates and manufacturing bile, is a very important cemetery for the destruction of organisms and certain waste products of digestion. In some patients, whereas the other functions may be carried on properly, the liver seems to be incapable of destroying certain waste products of digestion, and these when allowed to circulate, give rise to sleepiness with headaches and other disturbances.

Constipation, by which food is retained too long in the lower parts of the alimentary canal, is a very potent cause of headache.

So indigestion may produce headaches in many ways, and it is probably one of the commonest causes.

Another cause, is the breathing of sewer gas or the foul air in crowded rooms or bedrooms where the ventilation is insufficient. Various organic products are constantly being re-inhaled, poison the circulation and set up headache. This is a common cause of headaches in servant girls. Very often they sleep in small, insufficiently ventilated rooms, and these girls become anæmic, develop chlorosis, and constantly wake up in the morning unrefreshed and with a headache. Very often the headache can be cured by leaving the windows open. Adenoids and nasal catarrh are potent causes especially in children.

Then come the group of reflex cases. These, as I have said, account for a very considerable number of, more or less, continuous headaches. I do not know that we need go very elaborately into exact details, but reflex headaches differ entirely from others in the fact that they are associated with cutaneous tenderness; the other headaches, for the most part, not being necessarily associated with cutaneous tenderness. In this group, the passage of your hand over a patient's hair is painful. The pain, and this is its main characteristic, is not produced by pressure, but by gentle friction on the surface of the skin, or by passing a hand over the surface.

Reflex headaches in the occipital region are chiefly associated with defects in the liver, the intestines, or the pelvic organs, such as the testicles, the ovaries, or the uterus. A large number of digestive and genital disturbances are associated with occipital headaches.

The cutaneous tenderness may also be referred to the vertex, the parietal, or the temporal regions. Roughly speaking, the heart and lungs set up cutaneous tenderness in the anterior part of the head, the stomach and liver in the middle, and the lower abdominal organs in the posterior part.

Ocular disturbances, as you know, are common causes of headache, so much so, that probably of the reflex group about 80 per cent. are due to them. A certain number of visceral headaches are very persistent, but many of those which are due to the liver and stomach are only temporary. There is no doubt that one of the most common causes of recurrent headache, particularly if it has come on in childhood, is asthenopia of the ocular muscles. A moderate amount of astigmatism, with hypermetropia, is very exhausting to the muscles of accommodation. In the same way weakness of convergence induces a constant strain and is apt to cause headache. As long as such a person does not use his eyes too much and leads an open-air life, he will not have headache. It

is very common for students to come to the hospital practically free from headache, but after they begin to work in the wards, if they run down in health, ocular headaches develop. Ocular defects are the main factor in the production of megrim, that is to say, of headache limited to one side of the head.

Local disease in the eye itself, such as corneitis, cataract, glaucoma, suppuration or iritis, all tend to set up headache with cutaneous tenderness which is referred to one of the areas associated with the eye, which extend from the maxilla up to the vertex and are bounded laterally by a line from the vertex to the angle of the mouth; the headache of glaucoma is often referred to the temporal region.

Dental disturbances form perhaps 10 per cent. of this group. The incisors are associated with tenderness in the fronto-nasal region. The canine and the first bicuspid in the upper jaw are associated with tenderness in the naso-labial region. The second bicuspid is associated with tenderness which occurs over the superior maxillary, and sometimes in the temporal. The first molar sets up tenderness in the first maxillary. The second and third molars in the mandibular region. The anterior part of the area over the lower jaw below the ear is the mandibular, and the posterior part is the hyoid region.

We cannot speak quite so certainly about the lower teeth. But the first and second incisors, the canine, and the first bicuspid pretty certainly set up tenderness in what may be called the mental region. The second bicuspid is sometimes referred to the mental region, but more commonly to the hyoid, that is to say, the region a little below the maxilla. The first molar gives rise to tenderness in connection with the mastoid region, the angle of the jaw, the hyoid region, and the posterior part of the tongue. This is sometimes very noticeable. The wisdom tooth generally sets up tenderness in the neck considerably below the jaw, and the patient generally complains that his collar is rubbing, and that his neck is sore. These are the various areas associated with the different teeth.

The ear. Of course, ear pain may be partly due to some local lesion in connection with the mastoid or the maxillary region, in which case tenderness is noted on pressure behind the ear and lower down on the auricle, and also reflected pain with tenderness over the auricle.

Headaches arise in connection with defective nutrition, such as those due to exhaustion from loss of blood, over lactation, or to excesses in any form interfering with the nutrition of the brain, to overwork, or to violent emotion. Some of the most terrible headaches are those that develop when people have given way to great rage, or have been subjected to great mental strain, a condition of collapse with intense headache due to exhaustion of the brain ensues. To this list may be added the intense post-epileptic headache.

Clavus, a form of headache called hysterical, is very terrible and apt to mar life considerably; they are very difficult to treat and cure, because the causes are largely persistent and are due to the general instability of the individual under the disturbances of daily life.

There is only time to deal with a few questions in *treatment*. It is essential that treatment should be directed to the cause and not be simply palliative, although at the time immediate relief is what the patient demands; and when the cause is not immediately remediable it will be our first consideration. When the headache is severe, rest in the horizontal position in a darkened room, with the application of an ice-bag or evaporating lotions to the forehead gives most relief in toxic headaches, but where the extremities are cold and the patient is chilly, heat is preferred. Antipyrine ten grains, Phenacetine five grains with one grain of Caffein, Exalgine two grains, or Antikamnia ten grains are all drugs which give relief, and their main use is probably for the relief of headaches. It is most important, however, to see if the headaches are at all frequent that the patients do not fall into the habit of taking the drugs without advice, as when taken to excess they impair the health and the pains recur more often. Morphia should be avoided as far as possible, but in the agonising headaches of organic brain disease it is justifiable to use it, as it alone may be able to give relief. Headaches

due to exhaustion are relieved by hot soup, coffee, or tea, preferably the first. When the extremities are cold, a hot footbath with mustard is indicated.

The cases due to indigestion are very numerous, and their successful treatment is far from easy. Those due to over-eating are most quickly relieved by making the patient vomit, taking a purge, and for some hours taking nothing but water.

Those due to fermenting food may be prevented by the use of creosote, one minim, in oil in a capsule at meals, or some other antiseptic, with strict limitation of the farinaceous and saccharine elements in the diet. When the gastric secretion is defective an acid bitter mixture is indicated, while in other cases, more particularly in women, an aromatic alkaline mixture does best, given before meals.

Some of the intense headaches due to constipation are generally benefited by large enemata daily, in addition to laxatives.

The constant headaches of some women often tax our skill. When made worse by the erect posture, digitalis with an easily assimilated form of iron is often useful. Salicylate of Soda, a quarter of a grain of Cannabis Indica, 15 grains of ammonium chloride, or turpentine in ten minim doses have often been most successful.

Troublesome headaches in children generally owe their origin to lesions in the throat, eyes, teeth, nose or ears, and these must all be overhauled. The nocturnal headaches of syphilis require large doses of Iodides, and the neuralgic headaches of malaria, quinine.

Headaches of dental origin, often obtain relief with the pill of gelsemium and butyl chloral.

It only remains to speak of the large group of cases of hemicrania, and of so-called sick-headache, which owe their origin mainly to ocular asthenopia. The ocular origin is often not realized, because the eyesight is often not defective and good vision can be obtained by muscular effort. Moreover, when the error of refraction is only partially rectified, no relief to the headache is obtained. In addition to the ocular condition, there is generally a somewhat sluggish digestion, and in women especially, far too little liquid is drunk.

The headaches can be kept in check by wearing appropriate glasses; by leading a more open air life; (it has been noted that at the Sanatoria for phthisis, patients subject to migraine lose their attacks almost entirely); by taking a tumbler of water at night; by avoiding meat more than once a day; and in the worst cases by restricting the diet almost entirely to farinaceous and milk foods with fruit.

An attack may often at the onset be cut short by a dose of antipyrine and sal volatile, by a large draught of two to three pints of water, and if associated with constipation, by a large enema of hot water.

Prize Day, 1902.

Sir Joseph Dimsdale, Lord Mayor of London, in the presence of a large and distinguished company, performed the pleasing duty of distributing the medals and prizes to this year's successful students.

At half-past three o'clock, the Lord Mayor, accompanied by the Governors and members of the Staff, proceeded from the Court Room to the Theatre in the Medical School, where the Students and their friends had assembled.

Cosmo Bonsor, Esq., M.P., called upon Dr. Fawcett, Dean of the Hospital, to make his annual statement, which was as follows :—

My Lord Mayor, Mr. Treasurer, ladies and gentlemen: It is exceedingly pleasing for me to be able to read to you, on behalf of the Medical and Dental School of Guy's Hospital, a most satisfactory account of the work of the past year. I should in the first place like to refer to our School and its relations with the re-constituted London University at South Kensington. As you are aware, our School is one of the constituent schools of the University, which latter in a new garb, but under its old name, is making, and has made great alterations in its organisation, in order to fill its place as a real University, viz., one affording every facility for teaching as well as for the advancement of learning in its highest sense.

One of the most important changes that has taken place during the year has been the alteration of the Matriculation Examination. It is in the direction of increasing the choice of subjects and in somewhat limiting their number, although enlarging their scope; as a result, any student who has had a sound education should be able to pass this examination from School instead of, as heretofore in a large number of cases, requiring special preparation for it. The Doctorate of the University will then be thrown open to a far larger body of men, and that without in the slightest degree impairing its intrinsic value. It is a change which we

welcome most heartily, and believe that it will have a most beneficial effect upon medical education, especially in view of the magnificent opportunities for experience which the Metropolis, above all other places, must always afford.

In carrying out these and other equally important changes, several members from our own Staff have been playing their part in the Senate, the Academic Council, and in the Faculty of Medicine.

Our own special interest has been more than maintained during the past year owing to the marked successes of our students, and to them and their teachers the Medical School wishes to offer its most hearty congratulations.

Since the commencement of the academic year in October last, five Guy's men have obtained the degree of Doctor of Medicine, and one of them, Dr. W. H. M. Telling, the Gold Medal. Twenty-five men have passed the final examination for the "M.B." Degree, four of them obtaining Honours, Mr. H. C. Keates being placed in the first class in Medicine.

At the Intermediate M.B. Examination, in July, 1902, our students have met with great success, for they have secured three out of the four Exhibitions and Gold Medals offered to candidates for Honours at that examination. Mr. A. B. O'Brien, one out of many of our excellent students from New Zealand, obtained the Gold Medal and Exhibition in Organic Chemistry, and also the Gold Medal and Exhibition in Anatomy.

Another student from New Zealand, Mr. R. W. Allen, obtained the Exhibition and Gold Medal in Materia Medica, and in the fourth subject of the examination, viz., Physiology, Mr. C. M. Wenyon obtained the number of marks qualifying for the Gold Medal. Mr. Wenyon also obtained Second Class Honours in Anatomy, and Mr. Allen and Mr. Longson Honours in Physiology and Organic Chemistry respectively.

In addition to this list of Honours, sixteen of our students have passed this examination during the year, and at the Preliminary Scientific M.B. Examination a similar number have been successful, from among whom Mr. Kenelm Digby obtained Second-class Honours in Zoology, and Mr. E. W. Giesen, another student from New Zealand, similar Honours in Chemistry.

At both Oxford and Cambridge our students have met with a full measure of success, and from among their number five Cambridge men have been admitted to the degree of Doctor of Medicine and eight have completed the examination for the M.B. degree. At the examinations for the Fellowship of the Royal College of Surgeons of England, seven of our students have passed the Primary and twelve the Final Examination.

These successes, however, gratifying as they are, represent only a fraction of the progress made by our students, the larger number of whom do not aspire to academic honours, but among them the percentage of passes, both for the diplomas of the Royal College of Physicians and Surgeons and other examining bodies has been most satisfactory, and the School has equally to congratulate them and their teachers on the excellent results obtained.

In reference to this somewhat lengthy note about examinations, I may perhaps be allowed to shortly indicate the *practical* importance of these results so far as concerns the work carried on by our students and Resident Staff in the wards and Out-patients' rooms of the Hospital. I cannot, I think, do this better than by reading to you an extract from the Treasurer's Report for 1901, in which he says, "It is perhaps even yet insufficiently recognised, or known, how much depends upon the success of the School. The School supplies the Hospital with some 300 students a year to carry out duties of varying responsibility under the supervision and control of the Permanent and Resident Staff. The students, in the later years of their course, occupy positions as clerks and dressers in the different departments, and the efficiency of their work depends entirely upon the thoroughness of their education. Fortunately the reputation of the School enables us to count on a succession of fully competent men for the work, and so long as this is the case we are satisfied that the objects of the charity will be fulfilled.

But in addition to the work in the wards and Out-patient departments, there is an increasing demand for skilled scientific investigation in connection with the diagnosis and treatment of disease; new or improved methods are constantly being brought forward, and for the welfare of the patients it is essential that every advantage should be taken of them; in many cases this is rendered possible by utilising the services of those who have been trained in the School, or who are responsible for the work of the different departments; for example, seven years ago only 40 examinations were made in the bacteriological department in the interests of the patients, while during the past year there were more than 1,000. This affords a striking illustration of the expert advice the Hospital is able to obtain through its School, and of which it is daily making more use."

The last paragraph of the Treasurer's report brings me to another matter very nearly touching our School, viz., that of research. The work of a great medical school, such as this, is not alone concerned in education, nor in helping to carry on the work of the Hospital, but also in the scientific investigation of disease in our laboratories. In this direction the School has, during the past year, been able to extend its accommodation and increase its usefulness, owing to the generosity of one of our Governors—Mr. Robert Gordon—whose name becomes thereby associated with a previous benefactor—Sir Cameron Gull.

As announced in the Dean's report of last year, Mr. Gordon presented the Governors with a sum of over £6,000 for the endowment of a lectureship in Experimental Pathology, and for the equipment of a laboratory. To this post Dr. E. W. Ainsley Walker, late Radcliffe Travelling Fellow in the University of Oxford, has been appointed, and has during the past session delivered his first course of lectures. I am glad to be able to report that

his laboratory is now completely fitted for the purpose for which it was designed. It is hoped that this addition to our laboratory accommodation, in conjunction with that also made in the bacteriological department, will enable us to take our part in the investigation upon cancer which is about to be started under the auspices of the Royal College of Physicians and Surgeons of England.

The Medical School has also to express its gratitude to Sir Frederick Wills, another of our Governors, for his munificent gift of £5,000, to be used to replace the quite inadequate library accommodation the School at present possesses; this valuable addition to our school buildings is now in course of completion and will very shortly provide all our students with opportunities for study such as they never before possessed.

With regard to our Dental School the only reason that there are no such striking records to bring before you as in the case of the Medical School, is that no similar prizes are offered at their examinations. Notwithstanding, the results obtained are most gratifying to tudents and teachers alike, for no fewer than forty-one have qualified as dental surgeons by taking the diploma f L.D.S. at the Royal College of Surgeons of England, and forty-seven have passed the first professional examination towards the same end. The dental department itself has been much improved by the installation of electric light throughout, and of electrical power for driving the mechanical apparatus in the laboratory. Valuable additions have also been made in the teaching for our students in this department; a series of weekly clinical lectures on dental surgery has been started, and the services of Dr. E. C. Perry and Dr. Eyre have been obtained to lecture on Dental Materia Medica and Dental Bacteriology respectively.

I have now briefly to refer to the losses the Medical School has sustained during the year. Sir Henry Howse, the President of the Royal College of Surgeons, our late senior surgeon, has retired from active service on the staff. There is no one to whom the School and students is more indebted, for he had worked untiringly in their service for over thirty-three years.

The post of lecturer on Surgery, which he held jointly with Mr. Lucas, has been filled by the appointment of Mr. C. H. Golding-Bird.

Dr. Galabin has resigned the lectureship on Midwifery, and to this post Dr. Horrocks and Mr. Targett have been appointed joint lecturers.

Dr. Pembrey has been appointed to the lectureship on Physiology, and Dr. J. W. H. Eyre, an old Guy's man, recently lecturer at Charing Cross Medical School, to the lectureship on Bacteriology. Mr. Assheton, of Cambridge, has succeeded to the post of lecturer on Biology.

Mr. Laidlaw Purves has retired from the post of Aural Surgeon which he has held for a period of twenty-eight years; Mr. C. H. Fagge being appointed in his place.

Dr. H. L. Eason has been elected Warden of the College in succession to Mr. L. A. Dunn.

It is almost impossible to speak in a few words of the great loss the Medical School and its students have sustained in the death of Dr. J. W. Washbourn, at the early age of 39. Dr. Washbourn was already making a great name for himself in the pursuit of Bacteriology, especially in connection with the study of Pneumonia, for it was his researches in this subject which had brought his name so prominently forward both at home and abroad. By his death the School has lost an ardent scientist, a loyal colleague, and a firm and outspoken friend to all with whom he came in contact, and one whose name had already reflected much credit upon his School and Hospital. At the time of his death Dr. Washbourn was physician to the Hospital, and joint lecturer on Physiology, and lecturer on Bacteriology in its Medical School. Only recently he had returned from South Africa, where he had been acting as consulting physician to the Imperial Yeomanry Hospitals, both at Deelfontein and Pretoria. In this capacity, as elsewhere, his services were invaluable, and for them he was rewarded on his return by the bestowal of the C.M.G.

In connection with the late war in South Africa, I have also to record the bestowal of the C.B. upon Mr. A. D. Fripp, the Senior Surgeon and Chief Civilian Medical Officer to the Imperial Yeomanry Hospital, and of the C.M.G. upon Dr. S. E. Denyer, another old Guy's man now at Cambridge.

Out of the large number of Guy's men who went out to South Africa as combatants, civil surgeons and dressers, we have unhappily to tell of the deaths of no fewer than eleven. A memorial to them, the plans for which are now under consideration, will shortly be erected by their friends and fellow students within the precincts of their old school.

Cosmo Bonsor, Esq., M.P.: My Lord Mayor, Lady Mayoress, and ladies and gentlemen,—After the exhaustive and most interesting statement of our Dean, very little remains for me to say. I have always endeavoured to impress upon my colleagues and the Staff that the school and hospital are both allied in one common effort, namely, to do the very best to relieve humanity. The Dean has been good enough to deal almost exclusively with the history of the school during the past year. It will therefore be appropriate, perhaps, if I say a few words on what is purely hospital work. Our hospital during the past year has done a greater amount of work than in previous years, and one of the most disappointing parts of being its treasurer, or having anything to do with its active management is the fact that, while the demand for relief is continually on the increase, the means for meeting it does not increase in equal proportion. Week by week persons who come for relief, and who would be admitted if there were beds for them, have unfortunately to be turned away because there is no room. I cannot allude to two happier subjects than when I mention and remind you that our President, H.R.H. the Prince of Wales, and H.R.H. the Princess of Wales have paid us

two visits during the past year. In the first instance, they paid us a private visit, and went into every ward of the hospital, and saw the whole work of a great hospital like this, showing the keenest interest in it. On that occasion I was bold to assure our President that the promise made in this hall some five years ago to His Majesty, then Prince of Wales, would be fulfilled before Christmas in this year, namely, that all the wards which at that time were closed, would be open for the reception of patients. That is a very satisfactory thing to be able to say after five years of great anxiety. I should also like to mention that there are two other additions to the hospital which, now that our means are small, are absolutely essential, one the addition of two new operating theatres for the new wards; and the other more accommodation in connection with the out-patient department, if the work there is to be carried on efficiently and well. These two new operating theatres are now, I am glad to say, under order, the room having been made for them by the erection of the Henrietta Raphael Nurses' Home. The other useful work is one which, I regret to say, must be postponed until our finances are in a better position—the remodelling of our out-patient department, of which I know so well the whole of our medical staff are absolutely impressed with the necessity. And now, ladies and gentlemen, I have the pleasing duty of calling upon the Lord Mayor, one of our governors, to give away the prizes. I should like to remind you that it was one of the first acts of the Lord Mayor when he came to the Mansion House to give the hospitality of the Mansion House to the Governors of Guy's for the benefit of the hospital. (Applause.) He kindly placed the Mansion House at our disposal, and we met with a generous response on the part of the public which, I am bound to say, would not have been so great had it not been for his lordship's kindly assistance and generous support. In the last weeks of his mayoralty, in the last weeks of a year which, as far as he is concerned, has certainly been one of great work and one of great success, and one of historic interest, his lordship has tried to do his best, as a governor of this hospital, and to do his best for the great cause with which his name will ever be allied, namely, the cause of science. (Applause.) I have to ask him to-day to say a word of encouragement to the students and others who are working in this hospital and in the first place to give away the prizes. (Applause.)

The Dean then read out the list of medallists and prizemen, and each recipient on being handed his reward by the Lord Mayor, was heartily applauded by the spectators.

Open Scholarships in Arts.—Clifford Anthony Leo Mayer, Royal College of Mauritius, £100. Malcolm John Rattray, King's School, Bruton, £50. Thomas Edmund Ashdown Carr, Lancing College, Certificate.

Open Scholarships in Science.—Percy Strickland Mills, Dulwich College, £105. William Henry Trethowan, Technical School, Plymouth, £105. Charles Morley Wenyon, University College, Certificate.

Open Scholarship in Dental Mechanics.—Roland Glendining, £30.

Scholarship for University Students.—Arthur Frederick Hertz, Magdalen College, Oxford, £50. William Mayhew Mollison, King's College, Cambridge, Certificate. Ernest Cranmer Hughes, Clare College, Cambridge, Certificate.

Senior Proficiency Certificate.—Claude Tessier.

Junior Proficiency Prizes.—Frank Thomas Herbert Wood, £20. Frederick Harrold Lennox-Jones, Arthur Boniface O'Brien, Morris de Lancey Robinson, equal, £8 6s. 8d. each. Alfred Gwilym Jones, Certificate. Richard William Allen, Certificate. Herbert Andrew Watney, Certificate.

The Michael Harris Prize for Anatomy.—Arthur Boniface O'Brien, £10. Alfred Gwilym Jones, Certificate.

The Wooldridge Memorial Prize for Physiology.—Richard William Allen, Morris de Lancey Robinson, Frank Thomas Herbert Wood, equal, £3 6s. 3d. each. Walter Welchman, Certificate. Herbert Andrew Watney, Certificate.

The Hilton Prize for Dissections (1901).—Edward Crosby Peers, £2. John Edmund Spiller, £2. John Alan Campbell Greene, £1.

The Arthur Durham Prizes for Dissection.—First Year's Students.—William Henry Trethowan, £5. Stanley Arthur Piper, Certificate. Senior Students.—Richard William Allen, £15. Frank Thomas Herbert Wood, Certificate.

Dental Prizes.—First Year's Students.—Alfred Leighton Mason, £10. Felix William Parfitt, Certificate. Second Year's Students.—Harold Percivall Aubrey, £15. John George Morrell, Certificate.

Practical Dentistry Prize.—Horace Croot, £10. Harold Percivall Aubrey, Certificate.

The Treasurer's Gold Medal for Clinical Medicine.—Carrick Hey Robertson.

The Treasurer's Gold Medal for Clinical Surgery.—William Henry Bowen.

The Beaney Prize in Pathology (1901).—Herbert Stanley French, £34.

The Golding-Bird Gold Medal and Scholarship in Sanitary Science.—Burton Alexander Nicol, £20.

The Right Hon. The Lord Mayor, having distributed the prizes, said: Mr. Bonsor, ladies and gentlemen,—In congratulating the successful students who are according to their seniority of standing in the School to-day, I desire to express my appreciation of the honour conferred upon me in being selected to be the medium of handing them the rewards which they have won at Guy's Hospital School. I feel also assured that the recipients of these medals and certificates are equally proud with myself at being associated with such a noble institution as Guy's Hospital. (Applause.) This great Medical School, founded in 1769, has for 133 years been working and giving to the world medical and surgical knowledge in the persons of their practitioners for the benefit not only

of this Hospital, not only of the Metropolis, but for the benefit of mankind in general. I find among the prize-winners, names mentioned which also appear in the Dean's report as having achieved great success in the recent examination of the London University. In that connection it is especially interesting to note that three of the highest honours obtained have been by students who come from New Zealand. (Applause.) This is by no means the first instance of our brethren of the Colonies, and those who belong to Great Britain beyond the Seas, shewing that they are not only part and parcel of the British Empire when her integrity and honour are assailed on the field of battle, but that they are equally one in all that appertains, even in medical and surgical education, to the welfare of this country, and are determined to maintain her in the foremost rank. But if our medical schools are to continue in the foremost rank as centres which give the best and most advanced education both at home and in our Colonies, they must be provided with every facility for teaching and research; and to attain this and maintain it, I need hardly tell you, means money and considerable outlay. Hitherto medical education in London has been entirely carried on by voluntary and philanthropic help. Funds are provided by the students' fees, augmented by generous and ready-help from the Medical Staff, and to these sources alone is attributable the present state of efficiency, the modern requirements, the laboratories and necessary equipments of a great school such as this. And in this connection I should like to state that the medical profession who are associated with this Hospital has within recent years generously contributed no less than £49,000 towards the better equipment of the School. This is a matter, I think, which every student here in Guy's Hospital, and everyone of us who has the interest of the Hospital at heart, will always feel proud of, ascribing all honour to those who have so generously backed up their own individual conviction of the vital necessity of an efficient medical school in connection with this Hospital. I rejoice to think that our hospitals are maintained upon the voluntary system, but I am bound to say that there are many who ought to subscribe who do not, and speaking of our great hospitals I go further, and I say that our charities generally are maintained by the comparatively few, and large numbers, practically speaking, do not give one single sixpence. Our beloved King, when as Prince of Wales he opened this very building in which we are in 1897, ever sympathising with the hospitals and evincing great care and tender thought for his poorer subjects, used these pregnant and weighty words: "The Medical Staff have expended as much as they safely can, and it is to men of wealth and philanthropic aspirations that we confidently look for further assistance. When such men once realise that money given for the purpose of medical education directly benefits humanity—and I cannot doubt that that spirit which has prompted the British people to provide by voluntary effort what in other countries is provided by the State, will prove effectual in the present." These words, uttered by our King, should vibrate through the hearts of his subjects and meet with a worthy response; and among the many monuments which may be raised to his memory, among the many and noble and great works and actions which will remain in lasting memory of our beloved King, I venture to say that the most imperishable will be the assistance and support which he has rendered to the Empire, to the Metropolis, and to his subjects throughout the length and breadth of his dominions, and the succour and help he has given to the hospitals of London, and, through their medical schools, to mankind. (Applause.)

Robert Gordon, Esq: Ladies and Gentlemen,—It would ill become us to separate without a fitting recognition of the services which the Lord Mayor has rendered us. Some people have the idea perhaps that the office of Lord Mayor is not a very responsible one. If they will read the speech delivered by the Lord Mayor only two days ago in which he recapitulates the most important events of the past year in which it has been his privilege to take any part, I think they will realize that there is a good deal to be done by the Lord Mayor besides those brilliant functions which took place during the year, and which culminated in the coronation of our beloved Sovereign. Beside such functions as these the present little ceremony may be thought of little consequence by the man in the street, at all events. We, however, as governors, take a different view of it. By his presence here to-day the Lord Mayor has given official recognition of the great work being done at Guy's. The primary object in establishing the hospital at Guy's was to relieve sickness, and minister generally to the sick and wounded. That work has gone on increasing gradually, and it is noble work, and one which I do not hesitate to say is quite as important for the welfare of the Empire, if not more so, than any other work carried on. We are here educating young men who, in due time, will go forth taking their places in the world to extend the knowledge of Guy's. We are training here, too, numbers of nurses, who by their kindness and skilful treatment are so ably supplementing the work of the surgeon and the physician.—(Applause)—As Mr. Bonsor said, this is not the first occasion on which his Lordship has been pleased to show his interest in Guy's Hospital, nor can we doubt that he will continue to show that interest even after his retirement from official life, seeing that he is now one of ourselves, a Governor of Guy's. On behalf of the other governors, and staff, and students, and nurses, I take the greatest pleasure in proposing a very hearty vote of thanks to the Lord Mayor for his great kindness in coming here to-day, and for the great service he has rendered thereby to Guy's Hospital. (Applause).

Dr. Frederick Taylor (Senior Physician): Ladies and gentlemen,—I rise with very great pleasure to second the vote of thanks so ably proposed by Mr. Robert Gordon. To-day the Lord Mayor is here especially in regard to the medical school, and it is as a representative

of that school that I second the motion. I think one can easily see that the Lord Mayor has many links which really do bind him to the hospital and to this neighbourhood. He is already linked with the institution as one of its governors, and on that ground alone he is interested in the school. Then, again, the Lord Mayor is a functionary whose interest in Southwark must be considerable. Southwark is not exactly the City, but I believe there was considerable difficulty in distinguishing between it and the City once. Southwark has associations which date very far back, and I think there can be no doubt that the Lord Mayor's interest in Southwark is none the less than in former days because it has obtained the privileges and responsibilities of a municipal borough. There is another link between the Lord Mayor and this hospital, and it is forged in this way. The Dean has already told you that we are a students' college of the London University. Formerly we were called an affiliated school, and as that we had no rights whatever in the arrangement or constitution of the University. But now the medical schools are what are known as constituent colleges of the University. Their teachers form part of the faculty who are elected on the board of the University, and the schools take the advice of the board on various matters connected with the examinations and any difficulties that may arise from time to time. Therefore, the medical schools are more integral parts of the University than ever they were. The Lord Mayor is, *ex-officio*, a member of the senate of London University, and therefore his interest in Guy's Hospital Medical School is increased thereby. We know very well, too, the interest of the City and the influence that the City has had in education, and what large contributions the Corporation and City Companies have made towards that end, thereby bringing education of university rank within the sphere of very many who otherwise would not have enjoyed its advantages. The Lord Mayor was kind enough to make some remarks upon the question of ways and means, and the sinews of war, and methods of improving education in the medical profession generally and especially, perhaps, in connection with this hospital. We do thank him very much for those remarks and for the way in which they go to the root of the matter. It is a remarkable thing how the medical profession has had to go along by its own efforts almost entirely—by grants, and pensions, and subsidies, and so forth. An institution like this has not only to educate the students and fit them to become practitioners, but continually to be making fresh progress, fresh discoveries in the direction of art and science—medical and surgical. It is in hospitals that great discoveries of this kind have been made, or been developed. The discoveries of Lister were made in connection with hospitals, and the discoveries of every physician and surgeon have been made in a similar way, whether in England or abroad. Therefore, I say, that the hospitals and medical schools are required, and if they are to do efficient work it is necessary that they should be well supported. I, perhaps, may be allowed to point out that several honours have fallen to the members of the staff of Guy's Hospital: Sir Samuel Wilks, who is with us to-day, was only recently President of the Royal College of Physicians, and he was, moreover, the first president of Guy's Hospital; Sir Henry Howse has now for the second time been elected President of the Royal College of Surgeons; and Mr. Thomas Bryant and Mr. Fripp are surgeons in ordinary to the King. In their work all of them have developed science, and it is to this endeavour that I am sure the Lord Mayor's presence here to-day will have given an immense impulse. We are all very grateful to him for having presided on this occasion, and I beg most heartily to second the vote of thanks.

The Lord Mayor: Ladies and gentlemen,—I thank you not only on behalf of myself but also on behalf of my wife, the Lady Mayoress, and my Sheriffs, for I am quite sure that they have been equally gratified with myself in coming amongst you to-day. I congratulate my sheriffs upon this the first time that they have come to a public function, that it should have been for such a splendid object as to further, however little that may be, the interests of such an institution as Guy's Hospital. I only wish I could have done it before. I have been interested in hospital work as a layman for many years. I was on the house committee of the London Hospital for some time, but I think one of the greatest privileges which I have enjoyed in my year of office is this—I have been asked by three of our great hospitals to participate in functions such as this. I have opened those splendid new operating rooms at the London Hospital, I have presented the prizes at St. Bartholomew's, and I wind up, within a few months of my year of office, by undertaking a similar duty in Guy's Hospital. I can only say that I hope and trust that you students who have been the recipients of recognition to-day in the shape of certificates and medals will feel in after life, whatever portion of the globe you may go to, that you owe a lasting debt which can never be repaid for having such a school as Guy's. I thank you very much for the kindly welcome you have given me.

This concluded the interesting proceedings.

The following Programme of Music was performed by the Band of H.M.'s 2nd Life Guards, by permission of Col. Sir Audley Neeld, Bart., C.B., M.V.O.

March, "Hail to the Spirit of Liberty" (Sousa); Overture, "Light Cavalry" (Suppè); Walzer "Les Baisers" (Margis); Selection, "Tannhäuser" (Wagner); Three Dances from "Henry VIII." 1. Morris. 2. Shepherds. 3. Torch. (German); Selection from "The Toreador" (Caryll & Monckton); Cake Walk, "Dusky Dudes" (Schwartz); March, "Whistling Rufus" (Kerry Mills); Selection, "Carmen" (Bizet); Idyll, "Echoes of the Forest" (Piccolo—Musician Jesse) (Damarè); Intermezzo, "Amoureuse" (Berger); Selection. "A Country Girl" (Monckton); Valse, "Bleue" (Margis); "The Brooklyn Cake Walk" (Thurban).

South African Memorial Fund.

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Mr. Goldie	0	5	0
Mr. Copland ...	0	5	0
Mr. Ward	0	5	0
Mr. Smart	0	5	0
Mr. Houghton ...	0	5	0
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Mr. Farrant ...	0	2	6
Mr. Goodman ...	0	2	6
Mr. Hooper ...	0	2	6
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Mr. H. W. Jones	0	2	6
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Mr. Piper	0	2	6
Mr. Randall ...	0	2	6
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Mr. Green	0	2	6
Mr. H. W. Wallis	0	2	6
Mr. Poyton	0	2	6
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Electrical therapeutics can scarcely be said to be more than in its infancy. The advantages claimed for red, blue and white "light baths" are hardly sufficiently obvious to mark a sharp demarcation between science and quackery. Röntgen and Finsen rays are, however, of known and proved excellence in the treatment of skin and allied diseases, and it is in this connection that the Sanitas Electrical Company is worthy of note. The chief patent of this Company covers an apparatus for the production of ultra videt light waves. Briefly, it is an arc-lamp with water-cooled iron electrods, between which the arc plays at a pressure of two hundred volts. The current required is five amperes, hence the apparatus consumes exactly one Board of Trade unit in the hour. It is thus readily seen that the actual cost of running such an instrument, allowing "exposures" often minutes each, is very small, and the cost of upkeep, the replacement of the electrodes, is almost negligible, for the cast-iron points cost only a few pence a dozen. The general efficiency of the lamp is high, and the arc adjustment apparatus both simple and effective. We know of no better instrument, where mains are available, for the production of the Finsen rays than the Sanitas Lamp.

Passim.

Reference has been made in past issues of the Gazette to the great interest displayed by the Lord Mayor in the welfare of our hospital in the spring of the present year. This interest he has maintained throughout his tenure of office, and it shows how fully alive he is to the important part played by the great London hospitals in the maintenance of the health of the Metropolis. Not only has he associated himself with the hospital as an institution by presiding at the prize giving on the 1st of October, but he has shown a feeling of good fellowship with the students themselves by coming amongst us in the evening at the Annual Dinner.

Prize Day on October 1st passed off much as usual. Something was lost in attractiveness and colour from the grey of an October day and from the absence of summer dresses; something, on the other hand, was gained in the shape of the picturesque little civic procession which wound its way from courtyard to lecture theatre brought up by the magnificence of the Lord Mayor's footmen. The band itself was of the best, and the well-known strains of the Toreador or of Sousa's Marches penetrated to please the senses of patients in far-off wards and lighten the duties of those who were unable to wander with the throng. Tea arrangements in the new Library Buildings were above the average, and a large proportion of the visitors, who had an excellent excuse in the high wind and autumnal chilliness of the Park, kept the room fairly constantly full.

For those who wandered round the Hospital new attractions were provided this year in the shape of the display in the Skiagraph Department, and the ever-pleasing Otis electric elevator. Ladies who were able to overcome nervous apprehensions that one could see through them into their thoughts, took pleasure in seeking for warts on the bones of their hands in Mr. Shenton's department, and in playing with currents of half a million volts intensity, and when they tired of this they went for 'bus rides in the electric lift. The new Nurses' Home took a good place in the attraction list, and was shown off with great pride by nurses to their friends.

The time of year precluded any very brilliant flower display, but the wards were beautified with the best which early rising Sisters could obtain, and the results were excellent. So far as general arrangements went, everything passed off without a hitch, and Dr. Fawcett is to be congratulated on the success of his first Prize Day. The Stewards as usual ran about zealously with very little to do and did it very well. Later it was noticed that with the exception of an occasional outpost they gravitated to the tea-room, no doubt with the intention of supplying the wants of visitors.

In the College during the last two months we have seen some striking changes; the conditions under which we dined in hall this time last year are not such as we care to dwell upon; this year the dinner itself is, thanks to Mr. Wade, such as a man need not be ashamed to ask a friend to share. This is in itself a great advance; a good dinner, sordid though the platitude sounds, is a powerful factor in influencing a man's attitude towards the world. Another increase in our comfort, of perhaps more certain permanence, lies in the new electric lighting. Everyone has observed the fact that electricity has now been laid on to club and gymnasium, and some perhaps have asked whence it came; many have taken it as a gift from the gods, and have been content to take heaven's blessings without a question. It is to the kindly generosity of Dr. Pavy and Dr. Goodhart that we owe this addition to our club, and another item is added to the heavy debt which past, present, and future Guy's men owe to these two great predecessors.

Amongst the chief features of the House Dinner on October 1st, was the presence of them both. Dr. Pavy, with his 55 years of knowledge of Guy's, is known to the younger men better by his great reputation and by all that he has done for Guy's than through any personal acquaintance with him. Dr. Goodhart worked amongst us more recently and there

are still men here who were on his "firm" before he left us. We recall the superstitious awe with which one entered the Medical wards to work under him, with a mind full of the stories of his Gagoolian powers, whereby he would stand at one end of the ward and "smell out" the diagnosis of those at the other end. A little exaggerated, perhaps, but not without a foundation, as one discovered.

All the elements which tend to make a success of Going-off Dinners were present on the last occasion. Whilst there was not sufficient rowdyism to render discomfort to any one of the diners, there was sufficient *bonhomie* and conviviality to render every man's speech inaudible, and a pleasure to himself alone. On occasions such as these when a man speaks because he himself wishes to, and not because others really desire it, this is as it should be. As the evening advanced the speakers rose from floor to chair, from chair to table, and no doubt their sentiments and expression of ideas rose in proportion. Mr. Wacher's witticisms were the only ones which reached us and they made us long for more; unfortunately of all the speakers Mr. Wacher's expression and pose alone commanded silence, and we were disappointed.

The daily papers have recently disclosed a new advance in medicine in the discovery by a Vienna doctor of an antitoxin serum for use in scarlet fever. He injects the "streptokokken cultures of children stricken with the disease into horses" and uses the serum in the usual way. This is taking for granted that the streptococci which may be found in scarlet fever is the cause and not a septic accompaniment of the disease; even if the theory be acknowledged as correct, the results by which the mortality in 400 cases was lowered from 13·9 per cent. to 8·9 per cent. do not very much appeal to us. Taking over 80,000 patients from the Metropolitan Asylums Board during six consecutive years, the mortality works out at 5·3 per cent. Very possibly, however, the lay press is at fault in giving the impression that the treatment is intended by its promoter to be anything more than ordinary antistreptococcin injections for septic cases. It is far from uncommon for some unfortunate worker to have his work mangled and magnified and his ideas misrepresented in these days of imaginative reporters.

We publish in another column an interesting lecture on Diphtheria; its Cause and Cure, by a clergyman who throws an original and startling light on many points in general medicine which have previously been obscure. We have thought of offering the author as a case for diagnosis, and shall be glad to have suggestions. His age, so far as we can judge, is something over 2300 years, since he can remember when no one had heard of cancer; no wonder his wisdom is above that of other men. Occasionally epigrammatic, always startling, we fear that his views will revolutionise our out of date ideas, and rival those of the Christian Scientist. One grain of truth with which we can agree he utters. "There is no cure for disease if we go on taking the things that cause it. We must not eat what we like, but what suits us." The whole thing reminds us strongly of Dan Leno's well-known lectures on "Beauty" or on "Eggs." No doubt it really is intended to be looked on in a similar light.

For the most part the visit of the Lord Mayor to Guy's was viewed with unmixed pleasure; and yet there was at least one exception. As he passed along one of the accident wards one of the patients was heard to mutter, "'Ave I seed 'im afore? Yus, I should think I 'ave. Last time I see 'im I got three months 'ard." Truly the chief magistrate in London is a man with a wide acquaintance of men.

Attention is drawn to a letter amongst the correspondence from Mr. Henry Taylor. The last few years has seen the steady growth of the Students' Glee Club and Nurses' Choral Society under his able leadership, until at present there is but little need to appeal for assistance in their directions. They are old enough and strong enough now to stand and speak for themselves, but Mr. Taylor is anxious that the latest infant which he is bringing into our hospital life

should not die of malnutrition. In other words, he makes an appeal for men to come forward and help to produce and maintain a chapel choir which shall be worthy of the Hospital. We have every hope that amongst the four or five hundred men who claim Guy's as their Alma Mater a more than sufficient number are to be found with the will and the voice to do what our choirmaster asks. His plan is a simple one and is one which will make no great call on any man's time. It is, briefly, this :—

1. That forty to sixty members should be obtained.
2. That eight or ten promise to attend the Services on Sunday each month during term, or secure a substitute.
3. That members attend the rehearsals, which can be held on Fridays, after or before the Glee Club practice in the Court Room, viz., 5 or 6.30 o'clock.
4. That a choir committee be formed amongst the students, who will endeavour to influence others to join the choir, and ensure the attendance of members at the services and practice.
5. No subscription.

Men who are willing to join should send their names in to Mr. Henry Taylor or his coadjutor, Mr. R. Larkin.

We congratulate the Rugger team on commencing their season by defeating Kensington to the tune of 26 points to nil on Saturday. For the first match of the season they played together exceedingly well, and in a manner which augurs well for our chances this year. The forwards showed plenty of vigour and keenness, and the three-quarters have proved that they had lost none of their skill.

The practice game with which the club opened on Thursday previously, did not reveal very much in the way of the fresh talent which had been hoped for. Unfortunately there do not seem to be many freshmen up this term who play Rugby. However, in the forward line some promise was shown by Messrs. Pinching and Earle, and from the form shown by those who survive from last year's team we should have this year a fairly good pack.

Amongst recent literature by Guy's men, we note a paper by Dr. Pavy in the *Lancet* of July and August on the Acetone Series of Products in connection with diabetic coma. It has been reprinted in pamphlet form, and is a very interesting and concise treatise on the subject, illustrated by cases. The chief point which it impresses upon one is the much greater value of the estimation of the oxybutyric acid than of the diacetic acid.

Asphyxia and Death caused by a tooth in the Larynx while under Anæsthetic.

W. B., æt. 58, had an acute attack of angina Ludovici five months ago. This was treated by making numerous incisions in the neck under A.C.E. The acute inflammatory condition of the neck subsided to a certain extent, and the inflammation became more superficial. Two months after A.C.E. was again given, and a few more superficial abscesses opened. The patient improved in general condition as also did the neck, but two months after the second operation a brawny condition of the skin appeared behind the sterno-mastoid. His temperature again rose and his general condition became more serious, so it was decided to make a further incision with a view of letting out some deeply seated pus behind the sterno-mastoid muscle. He was prepared for the operation in the usual way, and a medical practitioner experienced in the administration of anæsthetics gave him A.C.E. ; after taking a few breaths patient said he wanted to spit ; the celluloid inhaler was removed from his face and he tried to spit and then said he was more comfortable, the mask was again put on his face and a few more deep breaths taken ; he became very blue and the mask was again removed, his condition improved and it was then suggested that chloroform should be given in preference to the A.C.E. mixture.

A piece of lint with less than half a drachm of chloroform was then put over his face ; after taking three or four deep breaths he suddenly became cyanosed ; his limbs became rigid, hands clenched, breathing completely stopped. The tongue was pulled well forward and artificial respiration was resorted to without any delay ; no air appeared to enter or leave the chest, so tracheotomy was immediately performed and artificial respiration continued. He improved slightly after the tracheotomy and a little air entered and left the trachea wound ; stimulants were given under the skin ; hot cloths to the heart, etc., but he never came round. Just before death took place the external jugular vein was opened with a view of relieving the extreme congestion of the face and brain.

Post-mortem.—The external tracheotomy wound was enlarged and the little finger put up the wound in the trachea towards the larynx, when a tooth was felt between the vocal cords. The larynx was then taken out and cut open from the posterior aspect, and a third molar tooth was present covered with ante-mortem blood clot. This

foreign body no doubt was the direct cause of death as setting up spasm of the larynx and asphyxia.

On opening the neck pus and inflammatory tissue was found extending posteriorly as far as the transverse processes of the cervical vertebræ, the trachea was pushed beyond the middle line by the inflammatory swelling. Tracheotomy certainly ought to have saved this man's life, but no doubt the deep inflammatory tissue round the trachea, and the weak condition the patient was already in, caused one to work at a great disadvantage.

The anæsthetist, I ought to state, enquired before commencing the anæsthetic if he had any loose teeth and the patient replied in the negative, though post-mortem the third lower molar on the opposite side of the mouth was also very loose. MONTAGUE WAY.

Kenilworth Lodge, Southsea.

My Final.

Strange it was that such a dreadful day should be so light and cheery, but so it was. I slept the sleep of the unjust like a condemned criminal, and wished still to sleep and perchance to dream, but it was not to be; for in a weak moment I had signed the fatal "pull-out" list, so I was torn from my couch by the ruthless Copsey. "Ten o'clock, sir" struck like a knell in my heart, which was already beating funeral marches to the grave. To me it was a day of sad reflection. All the wasted opportunities of a lifetime came before me in a reproachful procession, all my thoughts were introspective, and all trains of thought seemed to carry me fast to Bethlem.

I resolved to pull myself together, but my mind refused to be chained, and after notching my chin more than was absolutely necessary, I sought the dining hall. That old problem as to what kind of fish a doris was when he was at home promptly came up, and I paid much more attention to it than to the real business.

I started by hearing that "so and so" is a snip this time, so went to read it up; then I heard of something else and went again, but the third snip found me desperate and resolved to do nothing further.

Then mine own familiar friend whom I loved, lamented the fact that he was debarred from accompanying me by some formality, such as signing up, and envied me. I almost wept, and cursed the ambition which had hounded me on. Oh! how I long for the philosophic mood of a Teufelsdröckh, who looked on a man with ambition as a dog with a tin attached to his tail, and would have none of it. Ah! if I only had those guineas which I put confidingly in the capacious maw thrust out from the Hall-by-the-Sea.

Solace came suddenly and unexpectedly from the Candid Friend, who said, "Bigger fools than you have got through," and I thanked him simply, but with a whole heart. Almost automatically I reached the hall. The papers were much as usual, and we all wept together in unison.

My viva was a horror, and requires the genius of a Poe to describe it. I crept in awe stricken, and met the Grand Inquisitor, who is a mild mannered gentleman. He asked me quite simple questions, and I was almost insulted till I thought of the methods of the Inquisition. I saw that he was raising my hopes high and would then dash them down, but now he found a joint in my harness, and it hurt. I tried to think, and then spluttered out a very poor shot, and could think of nothing but the remarkable insight of Bacon when he wrote of Youth and Age: "Young men are fitter to invent than to judge," and I silently acquisced and "fitter for execution." As I was thrust forth a poor wreck of my former self, I solemnly concurred.

The awful suspense—the drinks that cheer and—and the successful termination some great writer may some day describe. It is beyond me. D.

Diphtheria: its Cause and Cure.

Interesting Lecture at Brigstock.

In a lecture on the above subject, the other day, the Vicar (Rev. J. P. Sandlands) said:—"It has often been said to me, when I have spoken of this illness, 'That is not your business, mind what belongs to you.' Is it not my business to do all I can to help people? One night, as I was going to bed, I was told that somebody wanted to see me. I went downstairs and found a gentleman in a great state of excitement. I went with him to his home, and found a boy who was apparently dying. That boy is now well and happy. If I had delayed ten minutes he would have been dead. It is our business to do good to our fellow-creatures. The son of a former member of our choir suffered from epilepsy. His mother had tried everything, but without success. She was advised to bring him to me. She did so, and this morning I wrote to her: 'Ernest may go home on Thursday.' He was quite well. Epilepsy is very dangerous, and often brings people to the grave. I have here a letter from a person out in New Zealand. You will remember last spring, Welton Clark was advised to go to New Zealand. He was consumptive. I told him the best thing he could do was to come here for the treatment. He refused. Then the doctors advised him to go to Bournemouth. I told him it was no good. He went, however, and got worse. Again he was advised to go to New Zealand. His wife would not stand in his way, and I told him it would be no use. He went to New Zealand and died there. A gentleman came to Brigstock from the very place where Clark had died, and was cured. I have another letter here from Australia. The writer says: 'We have just seen Miss Young and Miss Beck, and they told us what you can do.' She then asks me if I can cure her sister, who is ill. I told her, of course, that at that distance I could do nothing. There are other cases, too, which might be mentioned. So there is an answer to the question, 'What do you know about it?' These facts are the answer. Is there any doctor in England to

whom patients have come from Australia or New Zealand?

Another letter I have is from a gentlemen in Brazil, who was suffering from an issue in the throat—practically the same disease as the King has been suffering from. Nothing could cure him. He was ten months in the States, and got no better. He then came to Ireland, and after a while was told he could go back. I telegraphed to him to come here on Monday, but he could not come. I told him it was madness to return. At last he came. At the end of three days he said to me, 'I thoroughly believe in your system, and will do what you tell me.' In two weeks he was quite well and returned to Brazil. And yet people say to me, 'What do you know about it?' I mention these facts in order to show I have grounds for claiming your attention.

What, then, is diphtheria? It is a disease. A disease is something that throws our ease to the four winds. The word diphtheria means 'a double skin,' because the person who suffers from it has a double skin on the throat. But what idea does this convey? Ask a doctor what is laryngitis, and he will say, 'something wrong with the larynx!' Are we wiser? Doctors remove the effects, not the cause. What we want to know is, what is wrong? What is the cause?

About nine years ago there were 45 cases of diphtheria in the village, and not many were saved. We don't know the positive cause of diphtheria. It is one thing in one person and another thing in another person. The Sanitary Inspector looks round, and says there is nothing wrong with the schools. Last time there was an outbreak we had to spend about £16 having the schools whitewashed, but there was nothing wrong. I have been told two of the drains were stopped. Now here is the point: drains do not cause diphtheria, they have nothing to do with it. In Paris, London, and in other big towns men work in the drains and take no harm. He who says drains cause diphtheria talks nonsense. He has no proof. In Germany, in the country you will find outside the windows of the best rooms a large heap of manure, but no illness follows If these heaps of manure caused disease, they would not put it there. Typhoid fever at Stanion was said to come from drains in the house; how about the man who opened the drains? All my thoughts are well thought out. Milk doesn't cause disease. Boiled milk is spoiled milk. It is impossible to get diseased milk from the cow.

Water does not cause disease. There is a well in this village, the water from which contains iron. If you are quite well, this water won't hurt you; if you are not in a good state of health, it will make you ill. In Palestine, the dogs are the scavengers, and eat all sorts of filth. A Zulu woman once found a rotting sheep, cut out a piece of the liver, and gave it to her child to suck, without any evil result. People often eat game which has been allowed to get very much tainted. Putrid matter does not cause disease. What does then? No man can say positively what does cause disease. A while ago, a lady was here who ate three times too much, yet she was not fat; in fact she looked utterly miserable. How is it that if one big eater is thin, another is fat? I don't know. I daresay it is a matter of constitution, and strong secretive organs. In the other case the liver and kidneys don't work and so the work being left undone, the filth lodges in the body, and the person becomes fat.

What, then, is diphtheria? It is a disease which is often fatal. It is not altogether a throat disease. A child was buried this afternoon: she had been suffering from diphtheria. I saw her frequently. That which was the matter with the child's throat was not enough to kill her. Diphtheria attacks the whole internal regions. It comes from a disordered stomach. A man once asked me to see his child. I turned up her sleeve: she was suffering from malnutrition? The body has not enough nourishment. If the body is not sufficiently nourished it brings on different things. If we do not eat the right food, disease is produced. When I see children suffering from mal-nutrition I ask, what is their food? White bread and tea. It is not what we take, but whether it contains sufficient nourishment. Nature intends us to take milk slowly, in sips. A calf takes the milk slowly from its mother, so swallowing the saliva with it. Saliva must go with our food before anything can really be food.

Now I am going to speak about white bread and flour. You cannot tell what is in flour. But take oatmeal, and you can see it is all oats. White flour is made of anything not always from the finest wheat. I have lately found out that the wheat is ground and the coloured matter, in which all the nourishment is, is taken away. American wheat is mostly maize. Flour may be anything but what it should be. Even if it were the best, it is not nutritious. We might just as well eat chalk as white bread. People don't sell what is good for us: they sell because they want money. But the miller is to blame. The chief cause of diphtheria is probably eating white bread. No one can say positively what is the definite cause of any special disease, but all diseases are caused by the food we eat. Is there a cure? There is no cure for any disease if we go on taking the things that cause it. We must stop the cause. We must not eat what we like, but what suits us.

Disinfectants are not cures. I remember when there were no disinfectants; I also remember when nobody had heard of diphtheria, or cancer. Disease is neither infectious nor contagious. If it were, how could doctors and nurses go near the patients without taking it. There is no such thing as infection or contagion. And microbes do not cause disease. Maggots are microbes, but you eat them in cheese. So, too, are worms, gnats, etc., but they do you no harm. Microbes do not cause disease, but are caused by it. Twelve years ago I wrote to the "Times" and told people Koch's remedy for consumption was no good. The "Times" did not publish the letter, but people see now that I was right. One may eat as many microbes as one likes, and it will do no harm. A disinfectant does not cure disease. It is only a bigger stink, which covers a lesser.

Medicine is no use. Six months ago a boy of seventeen was seriously ill with pneumonia. His mother was a

sensible woman, and with her consent I stopped him taking any medicine or beef-tea. All he ate was a few grapes. He had no crisis. The day I expected it, he fell asleep, and when he awoke there was no delirium, and in three weeks he was out. Some doctors say medicine is a science; others say it is no science at all. They only give you medicine because so many people think they can't get well without it. The crisis is really the time when the system has to deal with the stuff we have put into it. Give patients nothing—perhaps a few grapes—but no beef-tea, no medicine, no eggs. Eggs are not made for food. Nature intended them for another purpose. You can't cure Nature. Animals won't eat when they are ill, and we learn a great deal from animals. When patients are convalescent, give them only grapes, and other fruits, and a little brown bread.

The cure, then, for diphtheria is to allow Nature room and occasion to throw off the disease by stopping the cause. The cause, as we have already seen, is unwholesome food—white bread in particular.—*Northampton Reporter.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Hospital Debating Society.

DEAR SIR,—We shall be glad if you will be good enough to allow us a small portion of your valuable space to draw the attention of men to the opening meeting of the Debating Society. We regret to have to announce the resignation of our illustrious president, Dr. Pavy, who has occupied the post since the inception of the Society. However, Dr. Savage has consented to reign in his stead and under these auspices, we are hoping to have a successful season. Our first meeting will be held in the Smoke Room, on Saturday the 18th October, when we hope there will be a large attendance to welcome our new President.

We especially invite freshmen and Junior men to turn up and take part in the discussion, as during the last season the secretaries have had, time after time, to call upon old and tried members to speak, owing to the dearth of newer talent, and on two occasions debates had to be abandoned on account of the lack of speakers. This really constitutes a serious menace to the future well-being of the Society, as when the present race of speakers have gone down, there is a grave danger of not sufficient members being left, educated in the arts of oratory and imbued with our traditions, to carry on the work of the Society successfully.—We are, sir, yours etc.,

E. HARRISON GRIFFIN.
RAY EDRIDGE. } Hon. Secs.

The Chapel Choir.

DEAR MR. EDITOR,—As you are aware, I am responsible for the better rendering of the musical portion of the Chapel service. At present the singing is done by the Nurses alone, and I am anxious that the help of the Students should be enlisted to make the Choir complete, so that we may be enabled to sing in harmony instead of unison.

I am sanguine enough to think, that if I am permitted to make an appeal to the Students through the columns of the GAZETTE, they will help me to carry out my desire to make the Service a special feature and worthy of the Hospital. I know there are difficulties to be surmounted but I think you can remember the early days of the Glee Club and Nurses' Choral Society, and I feel certain that you are as proud of the results of our perseverance and patience as I am, and for this reason I trust you will use your powerful influence to assist me in making a success of this new and, I think, most important step for the future improvement of the Chapel Service.

I am making this appeal to those gentlemen who are not members of the Students' Glee Club, as I shall bring the matter before the latter at our next practice meeting.—I am, dear Mr. Editor, yours faithfully,

HENRY TAYLOR,
(Choir Master, Guy's Hospital Chapel, and Conductor of Nurses' Choral Society and Students' Glee Club.)

24, Warwick Gardens, W.,
October 4th, 1902.

P.S.—My duties require my attendance at Guy's on Fridays (Glee Club and Choral Society practice), 5 to 9 p.m. Saturdays (Nurses' Choir practice), 8 to 9 p.m. Sundays, morning and evening service; and I should be glad to see Students desirous of joining the Choir on either of these days.

From the Gazette's Special Pathologist.

A.L.M., BOW STREET, R.S.O.—The sputum was muco-purulent in character, but after a long and searching examination we could find no tubercle bacilli in it.

F.P.S., WITHINGTON.—The centrifugalised deposit from this urine contained a small amount of pus with a trace of blood, and a fair number of urethral and bladder cells. Thus in addition to the urethritis there was distinct evidence of cystitis also. A careful search for the tubercle bacillus gave negative results. The specimen contained numerous extraneous organisms including some cocci, but was quite unsuitable for the detection of the gonococcus.

J.R.A., CHADWELL HEATH.—The tubercle bacillus could not be detected in this specimen of sputum, which was not of a purulent nature.

W., MIDDLESBOROUGH.—The tubercle bacillus could not be detected in this specimen of sputum.

PATHOLOGIST.

The Annual Students' Dinner.

The Annual Students' Dinner was held on October 1st, and was distinguished by the presence of the Lord Mayor, and a large section of the Staff. Dr. Goodhart took the chair.

In giving the toast of "The King," Dr. Goodhart said: My Lord Mayor and Gentlemen—The Students' Club will now drink the health of the King, and I would ask you to drink it in a threefold aspect. First, as His Majesty is the embodiment of the Imperial ideal which all Britons now so abundantly possess. Secondly, we will drink His Majesty's health as the personal representative and the titular head of the Royal House, which we all so much love and honour; and as the representative of our most gracious and beloved Queen Alexandra, and of our President, H.R.H. the Prince of Wales, and the Princess of Wales, and all the other members of the Royal House. Thirdly we will drink it, for our hearts go out towards the King himself with particularly personal affection to-day, when he has now recovered from his recent severe illness. God has saved the King. Let us hope that He has saved the King for many happy years, and for even greater use and purpose than ever before. (Applause.)

Dr. Goodhart next rose to propose "The Students' Club," and said: My Lord Mayor and gentlemen, it now becomes the duty of the Students' Club to drink to its own health and longevity, and I think there could have been no other time at which this club could more fitly drink to its own health. Many of its members have followed the fortunes of the King and their country in the late great Boer war—an episode in the history of Guy's Hospital which it surely cannot and never will forget, for it has lost some of its best, including, alas! our own ever-to-be regretted colleague and friend, Dr. Washbourn. But, apart from that fact, we have here to-night, it seems to me, an unusually representative slice of the Empire, and therefore this toast comes fitly after drinking what I may call the toast of Imperial ideal. We have the old hospital at our back, which, perhaps, we may not inaptly call part of the nation's joint loin. We have on my right hand the Lord Mayor of the City of London—(applause)—the Lord Mayor of Lord Mayors, and I do not think he will take it ill to himself or to his office if I call him the representative, the most able representative, of the heart of the Empire. (Applause). Well, then, a little farther afield on my right we have our Treasurer, who, as many of you know, is the guiding spirit of one of our great English railways—(applause)—and perhaps he will not take it ill if I call him the representative of one of the legs of the Empire; but I see around and before me many of the younger men who, I am sure, we all feel are part of the mouth of the nation. Therefore I think it is very fit that we should place our toast of success to the Students' Club and Guy's Hospital to-night so closely in juxtaposition to that of the King. It is no far cry from the Imperial sentiment to the local sentiment upon which I wish to enlarge for a short time to-night. It is 38 years to-day since I first entered or even saw the portals of Guy's Hospital, and in that space of time there is ample time for contrasts, as you may imagine. Those were the days of Koch and Hilton, and Targett and Poland, and Burlough, of Owen, of Fagge, Habershon, and Wilks, and Dr. Pavy, were assistant physicians in those days, and Cooper, Foster, and Bryant were assistant surgeons. These were giants in those days. Thank God one or two of them are left to us now! I sometimes wonder whether there are giants now. Those, too, were the days in which the budding students were informed as to how they should study medicine in an introductory address. Some still consider this auxiliary a useful institution, but personally, of all the addresses of the kind I heard, only one remains in my memory as a pleasure to have heard it. One other, perhaps, might have been a pleasure, and that was the late Sir William Gull's. But when he was announced to give the address, such a crowd came down to hear him that it was perfectly impossible for a tithe of us to get into the old anatomical theatre, and after some delay we all adjourned to the Bridge House Hotel, and then, after long waiting and much jostling in a room in which nobody could hear anything, the most brilliant of addresses was utterly wasted. Introductory addresses have passed from us these twenty-five years or more. Dr. Pye-Smith's was one of the latest, and though I did not hear it, I remember very well that the next morning we found his name published in the daily papers because he had given the advice to the students that it was waste of time to read them. Though I must confess I never followed the advice, yet it has become year by year more and more appropriate. In other ways there were contrasts in those days. We lodged in Merrick Square and Trinity Square and various outlying portions of the Borough. I daresay many of you live there still. There was no students' college in those days, and even in these I take it that the students' college has not ample enough accommodation. We lodged in those places and we fed at the Borough inns. I remember very well the White Hart and the Half Moon and the Ship and Shovel, and I think there was a billiard table there. The Borough inns are well known to fame, both literary and antiquary, but I fancy we are better off in these days in your more comfortable college. As regards recreation in those former days there was no really accessible place for physical recreation. There was, I believe, a cricket club, and the ever-to-be-remembered Josh Eno performed some astonishing feats in jumping and running. Now you have your Pavy gymnasium at your fingers' end, and not far off you have the Honor Oak ground, where I hope you gain cups and plates and health. Well then, in those dear old days when we were residents, I think Dr. Taylor and myself are the only ones of the particular period; Sir Samuel Wilks was a little before us. It is somewhat hard to speak of those days because the memory of those days still lingers, and it is difficult

even now at this distance of time to think that things can have been bettered, and yet I do not doubt that they have been bettered, and that you are gathering round this place now and accumulating such conditions and relations under a new regime as will enable you to look back in after years with the same affectionate remembrance as we do to those olden days. You do not see now the extreme specimens of various kinds of diseases that we used to see when we entered. I remember very well, when I first entered medicine in Guy's Hospital, that the little building which is now devoted to the study of electricity was then devoted to the housing of extreme forms of local inflammation and erysipelas, which I do not think the surgeons ever see now. It was quite a common thing with me to have to make on Monday afternoons three or four examinations of cases of pyæmia, a disease which I should think I am giving a little allowance if I say that our students see it three or four times a year. You know more about the more subtle forms of blood poisoning. Those coarser conditions which are more horrible to see hardly occur now. Perhaps the reason is that diseases alter because the place alters in which you treat them. Another reminiscence comes back to my mind. As an extern in the depths of despair, I remember going off to my first case and following a shameful specimen of humanity down the street that was called then and is still called Tooley Street, a squalid street, into a still more squalid corner of the Borough, which I believe was then called Star Corner. When I go into this quarter now, I walk down, by contrast, to a splendid boulevard, I pass by the approaches to a magnificent new bridge, and I look around and up and fancy that the Borough ladies must now be confined in palaces. (Laughter.) Of our dear old hospital and its emancipation from baldness and grey hair, and all that indicates senility and decay, I need not speak. You have our Treasurer and Dr. Perry always with you. You have only to look at the magnificent building over the way that T.R.H. the Prince and Princess of Wales opened the other day, and you have there, it seems to me, what must recall, if anything can recall, those splendid equipments, some of those magnificent old Roman baths. One other contrast I must make, and that is the Library. I hear that a new library is soon to be ours, furnished and equipped by the magnificent kindness of Sir Frederick Wills, one of our Governors, and people occupying such positions as I am to-night should take every opportunity of saying that our Governors have been splendidly munificent ones. (Applause.) I believe that no gift could be of more lasting benefit to the hospital and to the medical school than our new library will be. Books should have noble surroundings and be nobly housed. Just think now! Well may I see Dr. Pavy's book on "Things which you must not eat"—especially muffins. (Laughter.) I think, too, of Dr. Pye-Smith's and Dr. Taylor's "Medicines," and Mr. Jacobson's "Operations of Surgery." The Operations of Medicine are not written yet. (Laughter.) When gazing at these and other contents of the present library, you metaphorically stroke their backs all the time and say, "Poor things! in what mean surroundings are the mighty found!" (Renewed laughter). Well, now, I picture inside of this new library in the future our budding aristocracy of medicine and surgery sitting amid restful and thoughtful surroundings, or walking and talking amid those sordid piles and learning within its walls something besides what even those books can teach them. There was an article in one of the papers the other day on "The Charm of Chelsea." The writer of the article pointed out how, in walking in the confines of that interesting neighbourhood, it was easy at the sight of the past, to call back into almost close companionship the celebrities that almost infested that interesting part of the country. That, I fancy, falls in very much with my feeling to-night, and with what seems to me to achieve the virtue of a Students' Club. You think I belittle all the various activities of your comfort and health which sit around this building, but I value much more the associations within its time-honoured walls, and amidst the contrasts which have been forged and proved by time. Guy's Hospital goes on in continuous development, and this Students' Club, even on the spot, is old to the old and new to the new, and thus constitutes an influence which passes from the old order to the new. To these buildings, these rooms, these associations here, men's thoughts have reverted and will revert from the battle and strife of life. Each mind as it comes under its influences is carried back to those who have gone before, and catches up as it passes, those provisions and those dreams that link up an institution like this into a oneness, past present and future. And so the students' club has a great part to play as years roll on. It is an integral part of the hospital and is, so to speak, the mouthpiece of the hospital to transmit its influence from the old order to the new and to guide the spirit in the years to come. So, gentlemen, we may drink to-night success to the Students' Club with all heartiness and earnestness. Well now, there is no reply to this toast. I notice there is one health that we all love to drink which is not down upon this list to-night, and I am told that Mr. Bonsor, our treasurer, ruled it out in a modesty which is all his own, but which I must say, as far as my experience goes, is most unusual in the modern politician—(laughter)—therefore I shall respect his modesty. I see he has got a word or two to say by-and-bye, and so I am not going to ask him to reply. That will ease his mind. But I say that the hospital and school are one indissolubly, and that our treasurer was never more a treasurer than he is to-day. He is not only our treasurer, and head of the hospital and head of the school, but he is a practical student as well as us. (Applause.) Therefore in drinking success to the Students' Club, I think we will also drink to the health and prosperity of our much beloved treasurer. (Applause.)

Dr. Frederick Taylor: Mr. chairman and gentlemen, I do not think it has escaped the notice of this

company that we have distinguished guests present this evening. I have a little feeling of diffidence in approaching this subject now, because I have already made a few remarks on the same subject this afternoon. I was then seconding a vote of thanks to the Lord Mayor; this evening I have to propose his very good health. The Lord Mayor has done Guy's Hospital a great many favours in the year that has passed. (Applause.) I may briefly mention that he assisted the hospital at a meeting at the Mansion House, in an endeavour to get increased funds, and his assistance has been of the greatest value. The Lord Mayor was also present on the occasion of the opening of the Henriette Raphael Nurses' Home by T.R.H. the Prince and Princess of Wales. The Lord Mayor has come down here to-day, and we realise that he has spent the best part of a day in his attention upon Guy's Hospital. (Applause.) Therefore, I think that Guy's Hospital Students' Club have to thank the Lord Mayor for all that he has done for us. I wish we could feel that our present Lord Mayor was always going to be Lord Mayor. But as Tom Hood has said:

"To sink in state from high to lowly
Is a feat severe;
Chilled by the next November's blast
His blushing honours only last—
One year!"

Now, blushing honours are not the only qualification of the Lord Mayor. He has a vast amount of duties and obligations and responsibilities. As chief magistrate of London his work is not light. Therefore, I think we can see what sacrifices he has had to make in order to develope his interest in Guy's Hospital. I think I ought to mention—for perhaps everybody does not know it—that in connection with the medical profession, and therefore in connection with Guy's Hospital, we are indebted to the Lord Mayor for a very important innovation, namely, that at his annual banquet at the Mansion House the President of the College of Physicians and the President of the College of Surgeons were invited *ex officio* to be present as representing Surgery and Medicine there for the first time. Now, from my observations of the Lord Mayor I do not think he has really suffered from the infliction of his onerous duties. At any rate, he has always seemed to be, on the occasion of his visits here, in remarkably good health, and bearing those duties and responsibilities with equanimity. We could wish that Sir Joseph Dimsdale might have an opportunity of becoming Lord Mayor as often as his celebrated predecessor, Dick Whittington. One would like to know whether Sir Joseph had ever put himself in the way of obtaining these possible honours by listening on the top of Hampstead Heath for the sound of the Bow Bells. But if our wishes for this are not likely to be successful, we can, at all events, wish him long life and good health and happiness. We have another guest here whose name I should like to mention—our friend Dr. Pavy. Dr. Pavy is a special friend of the Students' Club, as we all know. Within a few yards of this spot, through his munificence not only has he provided a gymnasium for the use of the students, but he has recently added to the gift by providing it with installations of electric light. I do not think I need mention the names of the other guests present, but simply ask you now to drink their healths with the greatest heartiness, and with that toast I have great pleasure in coupling the names of the Right Hon. the Lord Mayor and Dr. Pavy. (Applause).

The Right Hon. The Lord Mayor: Dr. Taylor, Mr. Bonsor, and Gentlemen,—I have to convey to you, however feebly—it is certainly sincerely—my appreciation of the way in which you have received this toast, so extremely eloquently and far too flatteringly proposed by Dr. Taylor. There are one or two matters in it in which, perhaps, I ought to put the doctor right. It was not necessary for me to go to Hampstead Heath to hear the chiming of Bow Bells. The fact is that I was born within two or three hundred yards of the Mansion House, and therefore I am a *bona fide* Cockney. Whilst I was at school I used to consider it an insult to be called a Cockney; I now consider it one of the greatest honours. I have come to the conclusion that a Cockney is a genus that ought to be respected, probably the very best specimen of humanity, and to whom this country owes a very great deal. Now I have to thank you, first of all, or rather the Treasurer, I think, for enabling me to take part in a function to-day which has been entirely congenial to me. I realise only too fully that I have not done it well at all. (Voices, "No.") Many great and important men have undertaken functions such as I have taken to-day, and far better, but I yield to none in appreciating the honour that has been conferred upon me of being permitted to distribute the prizes to the successful students of Guy's Hospital. (Applause). This toast, sir, takes two aspects. First, I am Lord Mayor of London; secondly, it is in my individual capacity. As Chief Magistrate of London I feel proud to be amongst you. I feel proud to be here as the representative of the Corporation. I have many ramifications of charity and benevolence. My only regret is that the Corporation of London has not the expansive power which we should desire to have with a view of giving far larger grants to those noble institutions, the hospitals of London. I speak as one who has been associated with many hospitals of London. I own myself treasurer of more than one. I know from personal experience, and not merely from hearsay, the immensity of good that our hospitals do to mankind, and therefore it is but natural that I, as Chief Magistrate for the moment, should express the regret of the Corporation of the City of London, that they are not able to give tenfold more than they do into channels where every sixpence is absolutely well expended. Well, it seems incongruous that I, a layman, should be amongst you to-night, and yet it is not so very curious, because an ancestor of mine, my grandfather, more than a century ago, went over to Russia to inoculate the Emperor against small-pox. So that there is a sympathy and kindred feeling existing in my own mind from past reminiscences and one's

connection with the grandest of all professions, and hence I do not think there is any incongruity in my being here to-night. Whether I look upon it as being present in my own individual capacity as a citizen born and bred in the City of London, or whether I look upon it as a member of the City of London in Parliament, I have to thank you very cordially for permitting me to take part in a function to-day which I consider a great honour, and I further beg you to receive my thanks and appreciation for the honour you have done me in wishing me to come amongst you to-night. (Applause).

Dr. Pavy: Mr. Chairman, my Lord Mayor, Mr. Treasurer, and Gentlemen,—I cannot say but that I rise with mixed feelings. First of all, I have a feeling of satisfaction at being honourably associated with so high a personage as the Lord Mayor in responding to the toast, and I should have thought that the words which he uttered would have been quite sufficient without any words from me. But I cannot consent to shelter myself under the able words which have fallen from the Lord Mayor; I cannot shirk altogether making a few remarks upon this occasion. I am one of you and have been invited here as a guest this evening. I am the oldest amongst you. My recollection carries me back far longer than the recollection of our chairman; he spoke of thiry-eight years, I have to speak of fifty-five years. My entry to Guy's Hospital was in May, 1847, and during this period of fifty-five years I have known great changes to occur in Guy's Hospital. At that time we were in a flourishing condition as regards funds, and the staff of that time were all invited twice a year to dine with the governors (laughter) in the court-room of the hospital, and many evenings have I enjoyed at those dinners. I can recall the oratory of Mr. Gladstone; I can recall the speeches of Lord Cornwall—I am speaking of the early fifties—I can recall the beautiful language of the Bishop of Oxford, as he was first, and the Bishop of Winchester, as he became afterwards—I mean Bishop Samuel Wilberforce. Then came the agricultural depression, and Guy's Hospital became placed in a different position altogether. Our funds were reduced, and those dinners were no longer held. (Laughter.) But the governors were equal to the occasion. They appealed to the public for funds, and I think the first appeal was for five hundred thousand pounds The staff thought that they might as well ask for enough whilst they were about it, and I believe they were successful in getting it, or nearly so. At all events, a large sum of money was obtained. Looking at Guy's Hospital as it stands at the present time, I think I may say that the institution was never in a more flourishing condition, and, placed upon substantial foundation as it is, I think we may conclude that its flourishing condition will continue. My name has been referred to with regard to the gymnasium. I can only say that it has been the greatest satisfaction to me to render what may be of assistance to the students. I felt that it might be of advantage to the student if a suitable building were provided for him to go through physical exercises, and I had the greatest pleasure in making arrangements for the present gymnasium to be constructed. My sincere hope is that it will prove of advantage to Guy's students of the future, as I hope it has proved to those of the present and those of the past. I thank you most heartily for the manner in which you have received this toast. (Applause.)

Mr. Cosmo Bonsor: My Lord Mayor and gentlemen, Dr. Goodhart in his opening remarks was good enough to allude to the fact that I had refused to answer to the toast of the Students' Club. It was not from any wish to shirk my duties, but simply because I do not think it necessary to put the members of the club through the painful operation of listening for the fifth successive year to what little I have got to say. But if there is an occasion on which I can put the painful operation into practice, there could not be a pleasanter subject than our chairman, Dr. Goodhart. (Applause.) I propose his health. Dr. Goodhart is reported to have an enormous number of engagements, but I think that instructive and interesting speech of his showed us that he had been looking forward to this evening. Why I say so is because a friend of his met him the other day and told him of an engagement into which he had attempted to persuade him to enter for this evening, but all to no avail, for, as Dr. Goodhart said, "I am going down that night to take the chair at the Students' Dinner at Guy's, and there I am going to meet the Lord Mayor." The man in pity bemoaned the fate which awaited Dr. Goodhart's digestion, but his pity was unnecessary, "Had not Batten gone?" Dr. Goodhart alluded to the modesty of the modern politician. I do not know whether his eye was upon the Lord Mayor, who is the only active politician in the room. The modesty of the Lord Mayor is well known to everybody. But what about the modesty of the consulting staff of Guy's Hospital? There are two of them present this evening. The students' club wanted to have electric light and the governors of the hospital were willing to supply it, but the difficulty arose as to who was to pay for the installation, and those two gentlemen with a modesty which becomes them and a modesty of which every Guy's man is justly proud came forward and found the money. (Applause.) Dr. Goodhart, in refering to old traditions in connection with Guy's, told us that there were giants in those days. Well, gentlemen, for my own part I have no fear of comparison between the giants of those days and the giants of these days. I see before me our first student recruit from Egypt, and we welcome him most cordially, and I trust that he, being the first, will bring others into the great traditions of Guy's, which is cosmopolitan, and we are confident that when he and those who are entering our school to-day come to be in the position that Dr. Goodhart occupies, they will allude to those giants under whom they were privileged to learn, as "the great giants who were known in those days," and well uphold the traditions of Guy's in the future. I now ask you all cordially to drink to the health of Dr. Goodhart, and with Guy's musical honours. (Applause).

Dr. Goodhart then terminated the proceedings by a short speech, in which he recalled the story of the clergyman who proposed one minute sermons to a parishioner, and was met with the advice to make them sixty seconds shorter. He applied the story to his own present speech.

Cheers were then given for the Lord Mayor, Dr. Goodhart, Dr. Pavy, Mr. Cosmo Bonsor, Dr. Taylor, and other members of the staff.

Notice.

EXAMINING BOARD IN ENGLAND
BY THE
ROYAL COLLEGE OF PHYSICIANS OF LONDON
AND THE
ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Notice is hereby given that the following revised Synopsis of the Examination in Physics will come into force at the First Examination on and after the 1st May, 1903, viz.:—

PHYSICS.

GENERAL PHYSICS.—Matter. Simple Substances and Mixtures. Properties of Solids, Liquids, and Gases. Solution. Diffusion. Dialysis. Osmosis. Specific Gravity of Solids, Liquids, and Gases. Atmospheric Pressure. Air- and Water-pumps. Syphon. Barometer. Boyle's Law.

HEAT.—Temperature. Thermometers. Expansion of Solids, Liquids, and Gases. Conduction, Radiation, and Convection. Calorimetry. Heat of Combustion. Specific and Latent Heats. Freezing Mixtures and Freezing Machines. Vapour Pressure. Boiling Point. Hygrometry.

LIGHT.—The Action of the Prism and Lenses on Light. Reflection. Dispersion. The Spectrum. The Spectroscope.

ELECTRICITY.—Simple Forms of Batteries. Secondary Cells. Effects of Currents. Induced Currents and the Induction Coil. Electrolysis.

FREDERIC G. HALLETT,
Secretary.

31st July, 1902.

Pass List.

University of Durham, September, 1902.

THIRD EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

J. G. O. H. Lane, A. V. Maybury, A. A. Miller.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR IN MEDICINE.

A. A. Miller.

Nursing News.

MATRON'S OFFICE.

The Preliminary Nursing School was opened on October 1st. Miss Ada Fricker, who has been acting as Medical Night Sister, and Miss Enid Newton, late Matron of Easingwold Cottage Hospital, have been appointed instructresses. The Preliminary Nursing School has been especially designed as a part of the new Henriette Raphael Nurses' Home, and accommodates fifteen probationers, each of whom is provided with a comfortable bedroom, and there is a common sitting-room, with class rooms, lecture room, museum, and kitchen for sick-room cookery. The course in the Preliminary Nursing School comprises tuition and practical work in elementary anatomy, physiology, hygiene, dispensing, bandaging, the making of dressings, the use of instruments, bedmaking, housework, sick-room cookery, etc.

Nurse Stanyon, head nurse in Queen and Victoria wards, left the hospital on September 26th, after four years' service. Nurse Stanyon has been appointed night sister at the Royal Hants County Hospital, Winchester, and takes up her new duties on the 21st inst.

On September 11th, Probationer Carter was appointed to succeed Nurse Cameron as head nurse in Luke ward.

On September 26th, Nurse Lindon, head nurse in Job, left the hospital on completion of her three years' training. Probationer Tweedie has been appointed to succeed her as head nurse.

On September 28th, Nurse Lewin, head nurse in the Surgery, was transferred to Mary ward, and Nurse Cameron, head nurse in Luke, to the Surgery.

On September 17th, Probationer Pettit was appointed to succeed Nurse Milman as head nurse in the Out-patient department.

On October 2nd, Nurse Vivian was transferred to the Surgery, and Probationer Boodle was appointed to succeed her as head nurse in Lydia ward. Probationer Wilkinson was also appointed head nurse in Cornelius on this date.

Probationer Dann was appointed head nurse in Victoria ward on October 3rd.

Nurse Parr, head nurse in Astley Cooper ward, left the hospital on the 9th inst., on completion of her three years' training, and will take up her duties on the Private Nursing Staff after a short holiday. Probationer Horsepool has been appointed to succeed her as head nurse.

Sport.

Rugby Football.

GUY'S v. KENSINGTON.

Played at Wood Lane, in cold weather. Kensington kicked off, and the ball was well taken by O'Brien, who, however, failed to find touch with the return. Scrambling play followed, when Morgan made his mark, and found touch near their twenty-five flag. Here there was some loose play, both sides packing badly, and from a scrimmage Allen got the ball well away to O'Brien, who passed to McEvedy, who transferred to Alcock. The latter was hemmed in, but gave a return pass to McEvedy who had come round and was able to score wide out on the left. Morgan's attempt at goal failed.

A few minutes later Willan got the ball out to McEvedy who gave a good pass to Alcock, the latter running strongly and scoring behind the posts. O'Brien had no difficulty in converting.

The Guy's three-quarters were now playing well together, and another bout of passing between five of the outsides just failed through a faulty pass. Immediately after, McEvedy gained a lot of ground by a good kick, and the forwards following up smartly, were only prevented from scoring by one of the Kensington men falling on the ball. From the scrimmage which followed, the ball travelled towards O'Brien who took a flying kick which led to a rather lucky try, Morgan dashing up and securing the ball in the right hand corner. The kick at goal was a difficult one and failed.

Guy's were now leading by eleven points, which resulted in Kensington putting a deal more energy into their play. The forwards heeled out cleanly to Allen, but the latter was undecided, looking to right and left, and was brought down before he could pass. From some loose play which followed, the forwards dribbled towards the Kensington goal, and Milsom came very near scoring. We then had a free kick for off-side tactics by Kensington, but gained nothing. Kensington then had a free kick for a similar reason, but the ball was well returned to touch by O'Brien, and Kensington had soon after to touch down. On Kensington kicking-off, Harrison failed to gather the ball, and let them in our twenty-five, where our men had plenty to do to keep them out. Just now the forwards were playing a very loose game and packing badly, and Allen made a very dangerous high kick right in front of our posts, the pressure being eventually relieved by Thompson coming through with the ball and dribbling well down the field. Soon after, McEvedy gained possession and made a beautiful run right through the opposing backs, and scored in good position. O'Brien kicked a goal. Half-time.

On resuming, our forwards went off with much more dash, packing and following up better, and the ball coming out to O'Brien, the latter made a clever opening, passed out to Morgan who, with a dodgy run, got past the full-back and scored. No goal resulted, although O'Brien's kick was a good one.

Play then settled down in mid-field, and Allen made a very good opening and ran up to the full back, but a good effort was spoiled by a bad pass to Alcock. The forwards now playing well together brought the ball out to Allen, and it passed from him to McEvedy and O'Brien, the latter, however, giving a very hard pass which Morgan failed to take. The Kensington forwards were playing a boisterous game, the tackling being very keen, and a nasty rush was well stopped by Harrison. From a scrum near our twenty-five the ball passed through the hands of Allen, O'Brien, McEvedy, and Alcock, the latter running strongly from the half-way line, and scoring a try. The kick at goal was unsuccessful.

Our forwards, finding in Kensington a beaten pack, wheeled the scrum on two or three occasions with the ball, and Lee Saunders shewed good form, following up smartly. From a hard kick by one of our men the Kensington full-back made his mark. The ball was well taken by O'Brien, who ran round, transferred to Alcock who dashed down the line and scored in the corner. The kick at goal just missed. The whistle blew with our men in the Kensington twenty-five after a good dribble by Thompson. Score: Guy's, 2 gaols 5 tries; Kensington, nil.

Remarks.—The win was a good one, but it was not a very strong side against us, although we were handicapped by being without our usual halves. The three-quarters were very good, and should prove an excellent line this season. At half Allen played very well at times, but was frequently undecided, and seemed too anxious to play his own game. Of the forwards, Saunders was excellent in the open. Glendining and Anderson worked hard in the scrum. Tolhurst shewed great improvement on last year's form, putting a deal more dash into his play. Layton was not so good as at the trial game. One forward was a passenger—and a heavy one.

Births.

BURTON-BROWN.—On September 14th, at Via Venti Settembre, Rome, the wife of F. H. Burton-Brown, M.A., M.D. Oxon, twin sons.

HAYWARD.—On September 23rd, at 65, Stert Street, Abingdon, the wife of M. Cecil Hayward, M.A., M.R.C.S. of a son.

HINTON.—On September 20th, at Heytesbury, Wilts, the wife of Hammond T. Hinton, M.B., C.M., of a son.

MILTON.—On September 20th, at Southernhay, Westmount Road, Eltham, the wife of William Tayter Milton, M.S., M.B. Lond., of a daughter.

RICHMOND.—On October 9th, at 154, Jamaica Road, Bermondsey, S.E., the wife of B. A. Richmond, M.B., B.S., B.Sc., of a Son.

Ed.—A. P.

Contents.

	PAGE
Perforation of the Stomach as a Result of Malignant Growth: Clinical lecture by Dr. Shaw	429-437
Washbourn Memorial Fund	437
Correspondence: Guy's Hospital Clubs' Union; The Opening Dinner; Guy's Chapel Choir	438
The Physiological Society	438
Guy's Nurses' Choral Society and Students' Glee Club	438
Passim	439-441
Appointments	441
Papers by Guy's Men	441
Guy's Hospital Debating Society	441-443
Some Thyroids	444
Reviews	444-445
Sport: Rugby Football—Guy's v. Lennox; Guy's v. Cambridge University; Guy's v. Catford Bridge; Guy's 3rd XV. v. Merchant Taylors' School 2nd XV.; Guy's 3rd XV. v. King's College Engineers 2nd XV. Association Football—Guy 1st XI. v. Guildford; Guy's 2nd XI. v. Woodford Albion. Guy's Hospital Hare and Hounds	446-447

Calendar of Coming Events.

Oct., 1902.

Sat. 25.—Messrs. Golding-Bird and Dunn's take-in; Drs., R. Moyle and M. Bramley Taylor; Cl., M. Moiser.
G.H.R.F.C., I., Rosslyn Park, away.
II., Surbiton, away.
III., Kensington III., home.
IV., Wasps IV., away.
G.H.A.F.C., I., Surrey Senior Cup, 1st round.
II., Weybridge II., away.

Mon. 27.—1.15 p.m., Clinical lecture by Dr. Perry.
Last day for applying to Registrar for Form of Entry for M.D. and M.S. Lond.
Final M.B. Lond. Exam. begins.

Tues. 28.—1.15 p.m., Clinical lecture by Mr. Lucas.

Thur. 30.—Messrs. Jacobson and Fripp's take-in; Drs., J. W. Dadd and F. G. Goble; Cl., D. H. Trail.
G.H.C.U., Annual Sermon by Rev. J. Douglas, M.A.

November.

Sat. 1.—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., I., Richmond, away.
II., Croydon II., away.
III., Kensington III., home.
G.H.A.F.C., I., Surbiton Hill, home.
II., Hampstead II., away.

Mon. 3.—1.15 p.m., Clinical lecture by Dr. Horrocks.

Tues. 4.—1.15 p.m., Clinical lecture by Mr. Lucas.

Wed. 5.—G.H.P.P.S., Paper on "Hypnotism" by P. R. Bolus.

Thur. 6.—Probable date of Primary Fellowship Exam.
G.H.C.U., Address by Eugene Stock, Esq.

Fri. 7.—Probable date of 1st Professional and Final L.D.S. Eng. Exams.

Sat. 8—1 p.m., Clinical lecture by Dr. Hale White.
G.H.R.F.C., II., Rosslyn Park II., home.
III., Old Charltonians "A," away.
G.H.A.F.C., I., Ipswich Town, away.
II., Parthians, home.

Guy's Hospital Gazette,

OCTOBER 25, 1902.

Perforation of the Stomach as a result of Malignant Growth.

CLINICAL LECTURE BY DR. SHAW.

Gentlemen,—In a recent clinical lecture I brought to your notice a series of cases in which a communication was established between the interior of the stomach and the peritoneal cavity as a result of simple gastric ulcer. I urged upon you the necessity of early diagnosis of the condition, and immediate surgical treatment if the patient was to be saved from a speedy and certain death. Incidentally I referred to the fact that a similar accident occasionally took place in patients suffering from cancer of the stomach, and told you that the symptoms might then be very different and perhaps also the treatment, but time did not allow me to detail to you those differences. A few days ago a case of cancer of stomach died in the hospital as the result of perforative peritonitis. The patient was in one of Dr. Taylor's beds, and as the case had formerly been under my care in the out-patient department, Dr. Taylor has kindly allowed me to make use of the report as the basis of a clinical lecture.

In order to give you some idea of the infrequency of the condition, I may tell you that recently Dr. Perry and I have collected, for the purpose of another investigation, abstracts of all the fatal cases of cancer of the stomach recorded at Guy's Hospital up to the end of the nineteenth century. Reports are preserved since 1828, and in this period of seventy-two years we have found records of three hundred and five fatal cases of malignant growth of the stomach. Amongst these cases there are thirteen examples of a communication between the stomach and the general peritoneal cavity, so that we may expect this accident to happen in only 4 per cent. of the cases of cancer of the stomach that die in the hospital, and we must attend the post-mortem room daily for about five and a half years to have a reasonable chance of seeing a case examined.

Contrasting this with perforation of the stomach in simple gastric ulcer, I may remind you that in the lecture already alluded to (*see* Guy's Hospital Gazette, vol. 13, p. 285) I was able to give you details of four such cases all occurring in my own practice at Guy's Hospital within eighteen months, and all successfully operated upon by the surgeons who were called in. This difference in numbers might of course merely be due to the greater number of cases of simple ulcer than of malignant disease admitted to the hospital, but on reference to any series of recorded cases of fatal gastric ulcer you will find that the percentage of perforations is much higher than that I have given you for cancer. From 13 to 18 per cent. are figures commonly given in the text books.

For your convenience I have tabulated some facts abstracted from the reports of the thirteen cases in which a communication was established between the stomach and general peritoneal cavity, and have added to the tables particulars of six other cases in which a localized peritoneal abscess was found in connection with cancer of the stomach.

Before referring to these tables I will read you an abstract of the recent case which is compiled from Mr. Louisson's and my own notes of the clinical condition and from Dr. Bryant's report of the post-mortem appearances.

The patient was a tailor, aged 51, who between the ages of 30 to 45 used to suffer from severe attacks of abdominal pain associated with diarrhœa, but since that time had been in very good health until six months before his death. During the first four months of his last illness he lost flesh, became anæmic, and suffered from an inconstant pain around the upper part of the abdomen, with flatulence and nausea, but without any vomiting. Subsequently the pain lessened, he vomited frequently, and an ill-defined swelling was detected above and to the right of the umbilicus.

On admission to the hospital on March 31st, 1902, he was found to be very anæmic, the blood-count giving 10,370 white corpuscles and 3,400,000 red per c.mm. The temperature was 99·6° F.; the urine had a specific gravity of 1020, and was free from albumen. The abdomen was distended and tender at the upper part. No definite tumour could be felt.

April 4th. Gastric peristalsis was observed, the patient not having vomited since admission.

5th. The patient brought up a large quantity of fluid, in which no lactic or free hydrochloric acid could be detected.

8th. The vomiting continues, and on one occasion the fluid vomited was quite black. The stomach is to be washed out daily.

21st. The vomiting and pain have been lessened since the stomach-washing.

24th. There are patches of "thrush" upon the patient's tongue.

26th. To-day an anæsthetic was given and the abdomen examined. A large hard mass could be felt about five inches in length lying in a transverse direction three inches below the ensiform cartilage, and reaching one inch to the right and four inches to the left of the middle line. The mass was hard, nodular, and easily felt through the relaxed abdominal wall.

28th. Blood-count: white corpuscles, 11,300; red corpuscles, 3,100,000; hæmoglobin, 34 per cent.

May 1st. The patient was up as usual last night after tea, and seemed no worse. He had been washed out in the morning, and as was usual during the process, he had been very sick. At about ten o'clock at night he was seized with very acute pain in the abdomen. He sat up in bed, as he said the pain was much greater when lying down. The house-physician reported that the abdomen was moving on respiration and did not appear more rigid than usual. The pulse was 100. Two injections of morphia were given, and after the second the patient slept for about an hour. At five o'clock in the morning he brought up a large quantity of black vomit and became much weaker. At 5.30 he was pulseless; the abdomen was not tender. The patient died quietly at 7 a.m

At the autopsy the body was much wasted. The lungs were emphysematous. The heart muscle was pale and infiltrated with fat. There was some atheromatous change involving the aortic valves. There was a thick, goblet-shaped colloid carcinomatous growth involving the pyloric end of the stomach, sharply limited by

the pyloric ring, and extending along both curvatures towards the cardiac end for ten centimetres. The pylorus was much stenosed, but there was a narrow groove running just above the greater curvature where the growth had only slightly infiltrated the wall of the stomach, so that this might have served as a channel for the passage of the food. A perforation into the general peritoneal cavity, measuring about ten millimetres in diameter, had taken place in the middle of the anterior wall of the stomach five centimetres from the pylorus. The peritoneal cavity contained five pints of foul-smelling, greenish, opaque fluid. The perforation had smooth-cut edges, and around it, on the peritoneal surface, there were a good many old adhesions, so that it appeared as if the perforation had occurred some time before, but had been shut off from the peritoneal cavity by these adhesions and that some sudden exertion had broken down these adhesions, and so allowed the stomach's contents to extravasate into the peritoneal cavity.

The peritoneum over the stomach, and that in the immediate neighbourhood, was covered with nodules of translucent, jelly-like new growth. The omentum, mesocolon and mesentery were all affected by secondary growth.

I think you will all agree that I have been able to lay before you a very clear picture of a case of colloid carcinoma of the stomach proving fatal as the result of acute perforative peritonitis. The specimen is on the table, and you will be able to confirm the pathologist's description after the lecture.

[The condition is also shewn in the accompanying reproductions of two photographs of the specimen taken by Mrs. Toogood Hill.]

Now, although I do not wish to discuss with you the general questions of the symptoms and treatment of gastric cancer, there are one or two points that specially arrested my attention in watching this case to which I should like to refer.

The first point is *the frequency with which severe pain in all forms of gastric disease is dependent upon distension of the organ.* The fact that pain depended largely on gastric distension in this patient was clearly demonstrated to those of us who watched his case at Out-patients' before his admission to the wards. And in this connection it was interesting to note how the Out-patients' department obtained a quite unmerited credit for relieving the patient's symptoms. On the patient's second visit he was very enthusiastic as to the benefits he had received, the chief of which was the almost entire disappearance of pain within a few hours of his taking his first dose of medicine. The keen members of my out-patient class were preparing to carefully copy the prescription which had been so effective, when the patient went on to say, "I was very sick that night, and I have been constantly sick since, but I don't mind that; its nothing compared with the terrible pain I suffered before." I think, indeed, if you pay attention to the point you will be able to satisfy yourselves that in many gastric cases pain and vomiting bear an inverse ratio to each other. This may easily be explained if you regard the pain as due to distension of the organ, and when you have so simple a method at hand to overcome distension as is provided by a soft rubber tube, a funnel and a pint of water, it is well to bear this fact in mind.

This brings me to the second point—*the supposed danger of stomach-washing when ulceration exists.* The medical man who sent this patient to me and under whose care he remained till admitted to the hospital, wrote to me as follows: "I have not yet carried out your suggestion as to washing out his stomach, for the case looks each day more and more like cancer, and I am afraid there may be some ulceration." This fear that some danger may be done to an ulcerated surface by washing out the stomach is shared by a good many practitioners, while some still seem to regard the simple process of stomach-washing as a major operation under any conditions.

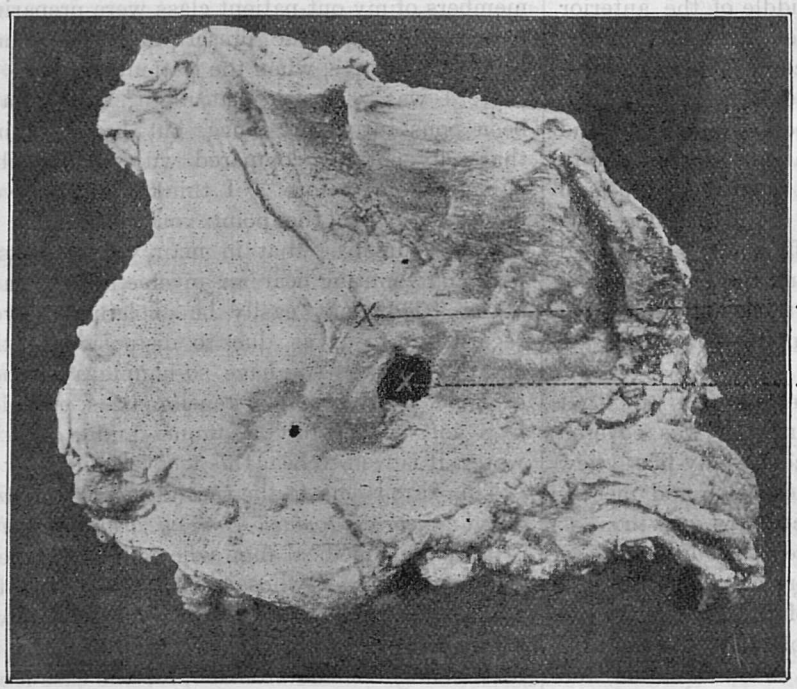
Undoubtedly evil effects have in some cases followed washing out the stomach, but this risk is so small and the good effect often so marked, that it is desirable that this prejudice should be overcome. You will notice in the abstract of this case that this treatment was constantly adopted in the ward, and with apparently good results. It is true the patient's stomach was

washed out about twelve hours before the perforation took place, but as the operation had been performed every morning for more than three weeks, it does not seem likely that there was any connection between the two events.

The last point I want to refer to is, *the advantage and possible dangers of palpation of the abdomen under an anæsthetic.*

On the other hand, in view of the pathologist's statement—"it appeared that the perforation . . . . had been shut off from the peritoneal cavity by adhesions, and that some sudden exertion had broken down these adhesions"—it is our duty to consider whether the palpation under an anæsthetic had anything to do with the separation of the adhesions.

The Pyloric Third of the Anterior Wall of the Stomach.



Exterior View.

The advantage of giving the patient an anæsthetic before palpating his abdomen cannot be better emphasized than by comparing the notes made after examination without and with anæsthesia:—

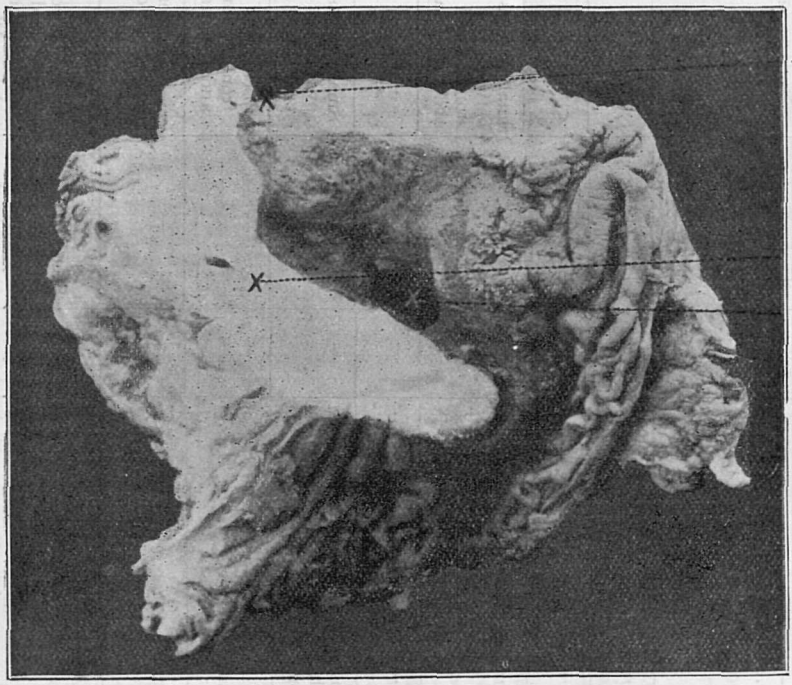
Without.—"No definite tumour could be felt."

With.—"A large hard mass could be felt about five inches in length, lying in a transverse direction three inches below the ensiform cartilage, and reaching one inch to the right and four inches to the left of the middle line. The mass was hard, nodular, and easily felt through the relaxed abdominal wall."

The anæsthetic was administered four days before the accident took place, and the examination was of course conducted with all gentleness. It is impossible to determine the point I have raised, but I welcome the opportunity of impressing upon you that when a patient is under an anæsthetic your manipulations should be very gentle. You have removed by anæsthesia the rigidity of the abdominal muscles which nature provided to protect the diseased viscera, and the patient can no longer warn you that you are on dangerous ground by shrinking if you cause him pain.

But we must now return to the main question which led me to choose this case for a clinical lecture, viz., the existence of perforation of the stomach. I have prepared a table giving some of the chief facts I have been able to learn from the reports of the nineteen previous fatal cases occurring in Guy's Hospital and have contrasted them with our recent case. I will not weary you by referring to all these cases in detail. If the Editor of the GAZETTE will be kind enough to print this table, those of you who are interested in the subject will be able to study it at your leisure.

THE PYLORIC THIRD OF THE ANTERIOR WALL OF THE STOMACH.



INTERIOR VIEW.

Some of the facts I would ask you to consider with me now. You will notice that, as in perforating simple ulcer, while the majority of cases die speedily from acute general peritonitis, a smaller number develop localised peritoneal abscesses and linger for a considerable time. Of our twenty cases, fourteen had general peritonitis and six localised abscesses. I cannot give you actual figures shewing the relative frequency of these two results in perforating simple ulcer, but my impression is that general peritonitis is much more common and localised abscesses correspondingly rarer. As you would expect, general peritonitis kills a patient much more rapidly than a localized abscess. The most speedily fatal case seems to be the one I am reporting to-day, for nine hours only elapsed between the sudden onset of acute abdominal pain and his death. The case which lived longest with general peritonitis was case No. 12, who lived five days, and it is interesting to note that he was the only patient who was well enough to be at work at the time the perforation took place. This is a point of striking contrast with perforating simple ulcer, the subjects of which are frequently stricken down while apparently in perfect health. Of the cases of localised abscess the longest survival after perforation seems to have been seventy-three days. I say "seems to have been" because this case illustrates the very common difficulty of

TABLE ACCOMPANYING DR. SHAW'S CLINICAL LECTURE ON PERFORATION OF THE STOMACH IN CANCER.

Case No.	Sex.	Age.	Duration of Illness.	Clinical Evidence of Perforation.	Duration of life after Perforation.	General Peritonitis.	Localised Peritonitis.	Situation of Perforation.	Reference.
1	M	51	6 months	Sudden acute pain	9 hours	5 pints of green opaque fluid	—	Anterior wall 5 centimetres from pylorus	The recent case under Dr. Taylor in Philip ward
2	M	43	12 months. Hæmatemesis at onset	Sudden severe lancinating pain in abdomen extending to the back	? 73 days	—	Abscess cavity from liver to spleen	1 inch from pylorus	Insp., vol. 9, p. 4
3	M	51	In hospital 6 weeks	[History incomplete]	—	2 pints of opaque serum and lymph	—	3 inches from pylorus in centre of a large ulcer whose base partly formed by liver	Insp., vol. 30, p. 92
4	M	65	In hospital 4 weeks	[History incomplete]	—	Yes	—	Lesser curvature	Insp., vol. 35, p. 358
5	M	—	—	[History incomplete]	—	Yes	—	Several places	Insp., vol. 36, p. 295
6	M	61	11 months	No evidence	—	—	Small abscess between stomach and abdominal wall	Anterior wall near pylorus	Insp., 1859. No. 118
7	M	43	In hospital 10 days	[History incomplete]	—	Yes	—	? pylorus	Insp., 1862. No. 176
8	M	56	In hospital 4½ months	No evidence. "Vomiting ceased and did not recur at all during last month: for this period he lay in an almost moribund condition"	—	—	Small abscess over lesser curvature	At edge of portion of stomach adherent to the liver	Insp., 1863. No. 64
9	M	45	Tumour 12 months	[History incomplete]	—	—	Abscess in front of liver and pylorus	Near pylorus	Insp., 1865. No. 172
10	F	56	In hospital at least 4 months	No evidence	—	—	Isolated abscess in lesser sac of peritoneum	Posterior wall near lesser curvature	Insp., 1871. No. 23
11	F	50	4 months. Hæmatemesis at onset	Sudden attack of abdominal pain	26 days	Yes Secondary to rupture of local abscess	A cyst containing chocolate-coloured fluid between pelvis and liver	Near pylorus	Insp., 1874. No. 476

Case No.	Sex.	Age.	Duration of Illness.	Clinical Evidence of Perforation.	Duration of life after Perforation.	General Peritonitis.	Localised Peritonitis.	Situation of Perforation.	Reference.
12	M	48	3 months	While driving a tramcar, sudden pain, so severe as to make him fall. Was admitted same day with symptoms of peritonitis. T. 100·5. P. 128	5 days	A quantity of bile-coloured fluid and lymph in cavity	—	Anterior wall near pylorus	Insp., 1877. No. 210
13	F	55	18 months	No evidence. "She gradually sank"	—	Yes	—	Close to under surface of liver	Insp., 1877. No. 444
14	M	49	6 months	May 18th.—On attempting to get out of bed he shrieked with pain. In the afternoon was again in great agony. 19th.—Dr. Fagge says: "I found him lying insensible, or nearly so, with white leaden lips and cheeks, apparently from the effect of internal hæmorrhage. There was no tenderness of the abdomen." 20th.—Died.	About 48 hrs.	A considerable quantity of puriform fluid	—	Middle of anterior wall	Insp., 1881. No. 144
15	M	39	Attacks of pain, vomiting and hæmatemesis 7 years	Feb. 13th.—Attacked with vomiting and severe pain in the stomach. P. 136 and small. Afterwards rallied somewhat, and died early on the 15th, bathed in perspiration	About 48 hrs.	"Much lymph and some fluid from the stomach"	—	Aperture size of pin's head on anterior wall near pylorus	Insp., 1882. No. 48
16	M	42	About 2 years	No evidence. "He gradually sank and died. There were no marked signs of peritonitis. He lay moribund several days before the fatal issue"	—	Purulent peritonitis, the abdomen containing 3 pints of turbid fluid	—	Not ascertained, owing to tearing in removal	Insp., 1891. No. 415
17	M	64	Over 4 months	No evidence. Diarrhœa and syncope day before death	—	Intestines covered with recent lymph	—	Lesser curvature, close to œsophagus	Insp., 1894, No. 176
18	F	56	About a year	"The prominent symptom was ascites. Growth of the stomach was not suspected, still less perforation"	—	13 pints of turbid fluid and a quantity of stringy lymph	—	Admitting little finger, close to pylorus	Insp., 1894. No. 423
19	F	40	12 months	No evidence. 18 days before death colotomy was performed for rectal growth, neither cancer of stomach or perforation being suspected	—	80 ounces of yellow fluid, containing much pus	—	Lesser curvature, close to pylorus	Insp., 1896. No. 253
20	M	63	11 months	No evidence. "He grew weaker and ascites came on, not apparently attended with any pain in the abdomen"	—	General purulent peritonitis: 126 ounces of turbid fluid	—	Anterior surface one inch from pylorus	Insp., 1897. No. 79

determining accurately the time of the perforation. The difficulty is two-fold:—Sudden severe abdominal pain may come on in patients with advanced cancer of the stomach from many causes other than perforation, and on the other hand perforation in cancer of the stomach may occur without giving any clinical evidence whatever. The absence of clinical evidence of perforation is well illustrated by our series of cases.

In fifteen cases the report is full enough to let us feel sure that no clear evidence of perforation would have escaped observation and record. In nine out of these fifteen there is no evidence. I will read you the final note made in the report of two of the cases in which the finding of a perforation at the autopsy was quite unexpected. No. 8.—"Vomiting ceased and did not recur at all during the last month. For this period he lay in an almost moribund condition." No. 16.—"He gradually sank and died. There were no marked signs of peritonitis. He lay moribund several days before the fatal issue."

Compare with these the abstract I have given you of the recent case, where the sudden pain was so severe as to induce the house-physician to give two hypodermic injections of morphia. Compare also the notes of two cases given in the table. No. 12.—"While driving his tramcar he was seized with sudden pain, so severe as to make him fall down." No. 14.—"On attempting to get out of bed he shrieked with pain. In the afternoon was again in great agony. 'The next day,' Dr. Fagge says, 'I found him lying insensible, or nearly so, with white leaden lips and cheeks, apparently from the effect of internal hæmorrhage. There was no tenderness of the abdomen.' The next day he died."

Leaving you to discover for yourselves by a study of the table how far age or sex has any influence in deterring the perforation of a cancer of the stomach, the effect of perforation on the average duration of life in this disease, the probable situation of the perforation, and the influence of its site in inducing general peritonitis or localised abscess, I will content myself by stating three important conclusions already established, and endeavouring to explain them.

1. Perforation of the stomach is rarer in cancer than in simple ulcer.
2. Perforation of the stomach in cancer frequently leads to a localised peritoneal abscess.
3. Clinical evidence of perforation of the stomach in cancer is often absent.

You will have little difficulty in understanding the greater frequency of perforation in simple ulcer than in cancer if you will compare the specimens of the two diseases on the museum shelves. In many cases of cancer there is no ulcer, or ulceration only affects the superficial parts of the growth. But even when a malignant ulcer destroys the coats of the stomach, the destruction is usually more than compensated by the deposition of new growth in the wall forming the base of the ulcer. If the ulcer extends quite through the stomach wall, communication with the general peritoneal cavity is frequently prevented by adhesions or by extension of the growth into adjacent structures. It is these adhesions, too, which account for the frequency with which extravasated gastric contents become isolated and a localised peritoneal abscess is produced.

In explanation of the absence of clinical evidence of perforation, there are several factors to be considered. The most important is probably the serious condition of the patient at the time of the accident. Many cases are lying moribund when the extravasation takes place—they are insensitive to pain and have not sufficient vitality to respond to reflex irritation by vomiting or by exhibiting rigidity of the abdomen.

Another possible explanation is to be found in the character of the contents of the stomach. In simple gastric ulcer the symptoms of perforation are known to vary according to the period since a meal and the nature of the last food taken. This being so, it is not to be wondered at if the small quantity of milk which a patient suffering from advanced gastric cancer is able to take does not set up violent irritation of the peritoneum when extravasated into it. Possibly, too, the absence of free hydrochloric acid from the gastric juice in cases of cancer

may lessen its power of irritation. The peritoneum itself is often already affected by cancer, and may contain a considerable quantity of ascitic fluid whereby the extravasated gastric contents would be diluted.

However this may be, the fact remains that in the majority of cases the onset of this fatal condition is unaccompanied by any warning signs. Still there can be no doubt that in some cases sufficient symptoms are produced to enable a diagnosis of the condition to be arrived at with a fair degree of certainty. It remains, therefore, to be considered what treatment should be adopted when such a diagnosis is made.

When speaking to you of perforation in simple gastric ulcer, I insisted as emphatically as I could that instant laparotomy should be performed. Does this rule apply also to perforation in cases of cancer? There are two great differences to be dealt with. In the first place, the patient is usually in a much worse condition to stand a severe operation. He is already exhausted and emaciated by cancerous cachexia. In the second place, he is the subject of a disease which, however successful you may be in combating the immediate effects of the perforation, must undoubtedly prove fatal at no very distant date. Each case must be considered on its merits. But just as we do not, if we can avoid it, allow a patient to bleed to death from cancerous ulceration or to die from unrelieved cancerous obstruction of the bowels, so we must not let one die of perforative peritonitis if we can by any means diagnose the condition while his strength is sufficient to bear the necessary operation.

Pass List.

University of Cambridge, October, 1902.

Admitted to the Degrees of Bachelor in Medicine and Surgery.

E. H. Kitchin.

University of Durham, September, 1902.

Final Examination for the Degree of Bachelor in Medicine.

G. Warwick Smith.

Washbourn Memorial Fund.

A fund is being started to raise a memorial in Guy's Hospital to the late Dr. Washbourn. The subscription is limited to sums not exceeding two guineas, and should be sent to Dr. Beddard, 44, Seymour Street, W. The following subscriptions have already been promised:—

	£	s.	d.
Dr. Hale White	2	2	0
Dr. J. W. Eyre	2	2	0
Mr. W. W. C. Pakes	2	2	0
Dr. E. I. Spriggs	2	2	0
Mr. Golding-Bird	2	2	0
Mr. Lane	2	2	0
Mr. F. J. Steward	2	2	0
Dr. Fawcett	2	2	0
Mr. Fripp	2	2	0
Mr. Lucas	2	2	0
Mr. Symonds	2	2	0
Dr. Pitt	2	2	0
Dr. Bryant	2	2	0
Mr. Targett	2	2	0
Mr. W. H. A. Jacobson	2	2	0
Mrs. W. H. A. Jacobson	2	2	0
Dr. Taylor	2	2	0
Dr. A. Elliott	2	2	0
Dr. Shaw	2	2	0
Dr. W. H. Cross	2	2	0
Capt. Hon. F. S. Jackson	2	2	0
Dr. Beddard	2	2	0
Hon. Mrs. Beddard	2	2	0
Dr. Wade	1	1	0
Dr. Pembrey	1	1	0
Mr. Swan	1	1	0
Dr. E. W. A. Walker	1	1	0
Mr. C. H. Fagge	1	1	0
Dr. Hyslop	1	1	0
Dr. Stevens	1	1	0
Mr. G. B. Smith	1	1	0
Mr. W. Ramsden	1	1	0
Mr. Ormond	0	10	6
Mr. Eason	0	10	6
Dr. French	0	10	6
Mr. G. S. Morris	0	10	6
Dr. P. Turner	0	10	6
Mr. G. S. Simpson	0	10	6
Mr. H. T. Hicks	0	10	6
Mr. F. E. Fremantle	0	10	6
	£61	19	0

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Guy's Hospital Clubs' Union.

Dear Sir,—I beg to direct the attention of members of the Clubs' Union to the following letter from Dr. Perry:—

> Dear Mr. Steward,—I regret to say that I found a considerable amount of wilful damage done in the swimming bath on my visit there yesterday, presumably by members of the Clubs' Union using the bath. I need hardly point out that it would be impossible for the Governors to continue to permit the use of the bath to students if such mischief were repeated, and it would probably be necessary that the Clubs' Union should engage an attendant on the days on which its members are to enjoy a swim. For every reason it is to be hoped that the necessity either of closing the bath to students or of employing an attendant, will not arise; and I think that if means were taken to bring home to your members the certain consequences of misconduct, even on the part of a few, public opinion would be strongly against the offenders.—I am, dear Mr. Steward, yours sincerely,
>
> E. C. PERRY,
> Superintendent.

The above letter is so clear that it is needless for me to add anything in explanation. I trust that its importance will be fully realised.—Yours truly,

F. J. STEWARD,
Hon. Sec. Clubs' Union.

The Opening Dinner.

Dear Mr. Editor,—Your reporter in the last number of the Gazette has done something to bring down my grey hairs in sorrow to the grave. He has committed me to calling our buildings *sordid*. I was carrying my mind forward a hundred years when the Wills' Library and the College should have been peopled with many another Addison and Bright, and Moxon and Wills, and when mellowed by "that incomparable artist, the London atmosphere," our future students may call them "storied."—Your truly,

JAMES F. GOODHART.

25, Portland Place, W.

Guy's Chapel Choir.

Dear Mr. Editor,—I am glad to be able to state that in reply to the appeal which I made to the students in last week's Gazette, more than half the number required to start the Chapel Choir have given in their names to Mr. Larkin during the past week.

We are very anxious that the junior students should take a warmer interest in the movement, and think many would like to join the choir who now hesitate to give in their names, being under the impression that only older and more experienced men would be qualified to become members. I would desire such students to banish those ideas from their minds, and to tell them that the necessary qualifications are—a slight knowledge of music, earnestness in the cause, and determination to attend the practices as often as possible. Then the voices and knowledge of the duties would rapidly improve.

Junior students (especially the budding tenors) would be welcomed at the rehearsals of the Students' Glee Club on Fridays (5 to 6 o'clock), where they would find scope for exercising their talents, and the hour spent in singing would prove a healthful, exhilarating and pleasurable recreation.—I am, dear Mr. Editor, yours faithfully,

HENRY TAYLOR,
Choir Master.

The Physiological Society.

The third general meeting of the Physiological Society was held on October 9th. It was decided that meetings should be held on alternate Thursdays at 4 o'clock during the winter session, but would be discontinued during the summer.

There was a balance in hand of £6 8s. 11½d., and it was decided to spend half of this in buying books for the Physiological Library. [Delicate arithmetic this.—Ed.]

The prize for the best paper was awarded to Mr. E. W. Routley. "Consciousness" was the subject.

The following officers were elected for 1902–1903:—President: Dr. Pembrey. Vice-Presidents: Dr. Beddard and Dr. Spriggs. Secretary: W. H. Miller. Committee: Mr. de L. Robinson, T. H. Barton, P. S. Mills and G. N. Bartlett.

Guy's Nurses' Choral Society and Students' Glee Club.

Conductor - - - Mr. Henry Taylor.

The next concert will be held on December 9th, 1902, when will be performed "The Banner of St. George" (Elgar), "Lord Allin's Daughter" (Gaul), two trios for soprano voices, male voice quartettes, Handel's duet for two basses, "The Lord is a man of war," and other part music.

Rehearsals on Fridays—Students, 5 to 6 o'clock; Nurses, 7.45 to 9 o'clock. Combined choirs on alternate Fridays, November 7th and 21st. Hon. Sec. N.C.S: Sister Rennie. Hon. Sec. S.G.C.: H. Tipping.

Passim.

To-day the Royal Procession will pass close to our gates and afford great pleasure to many thousands of His Majesty's most loyal and devoted subjects. The King has peculiar claims to our esteem: he was President of the Hospital in a time of great financial stress; his labour was hard and ungrudging, but his personal interest was ever manifest and sincere. When he severed his official connection and ceased the frequent visits, official and private, he was replaced by his well-beloved son. And as we see in him that restoration to health and strength that we have so often been able to afford the meanest and most lonely of his subjects—our special and peculiar pride—the thought must arise that the great labour and trouble he ever took on behalf of the sick poor, the hospitals, the nurses, and the healing art in general, has indeed returned to him fourfold.

"LONG LIVE THE KING."

Many of Dr. Pye-Smith's former clerks will eagerly take the opportunity of welcoming him down to Guy's once more on Wednesday, October 29th, at 4.15, when he will preside as of yore over the general annual meeting of the Students' Club, where the ordinary business will be transacted. It is hoped that all who can will endeavour to be present, and that all suggestions and complaints, if any, will be given notice of and investigated.

Dr. Pye-Smith will doubtless remember the time when he presided over the stormy tobacco meeting, when the exponents of the ubiquitous pipe or cigarette turned up in force, and how the two packed and excited meetings eventually resolved to maintain the *status quo*, a decision which gave such entire satisfaction that all recollection of any contrary desire has almost died away.

All who have ever been through Clinical (graduation it might be termed) remember some nights when "on horror's head horror accumulated," and urgent operations have ceased only between two and four in the morning, and of late there have been, though not confined to one ward, some of the traditional "busy evenings" that one occasionally hears were only seen in the good old days. For instance, there have been three Cæsarian sections within eight days, all successful, in the Guy's Charity, and on the last occasion it coincided with "version" and "axis-traction forceps," in another place, while in Clinical Mr. Lane was operating on a perforated gastric ulcer, and in the surgical wards on an obscure urgent abdominal condition hinted at darkly as a "suppurating hernia." Not a bad evening's work for those wise men who live in the immediate vicinity while dressing.

W. H. Harsant, Esq., F.R.C.S., has retired from his position as surgeon to the Royal Infirmary, Bristol, amid universal regret, after holding his appointment for 24 years. He was a Guy's man.

Little comment is required on the letter about the damage done to the swimming bath. Students are admitted by the indulgence of the House Committee, and if the reckless user of the bath is not restrained by his fellows, the students will probably lose the use of the bath altogether. All the residents in the College owe it to themselves and to their successors to see that by no act of theirs can such an unpleasant incident occur again, and it is the bounden duty of all gentlemen to observe, and also to see that others observe, a scrupulous care for the bath and fittings, to which they are admitted as an act of courtesy. If anyone is noticed misbehaving, we can only say "Don't nail his ear to the pump," but inform the President of the Residents.

At most meetings of the Gazette Committee the Editor and others are usually invited to express any opinions they may hold towards increasing the popularity of the Gazette, and for the most part the suggestions are not helpful. It is a very extremely difficult matter to say what it is that men like to find, when with ill-

disguised eagerness they open their fortnightly magazine. But at all events it would be extremely gratifying to the Committee if the *readers who receive it by post* would let us know what features they approve of and what they lack. Criticism from men on the spot is not difficult to elicit.

The body of the most issues of the Gazette is occupied by official reports, clinical lectures, and the like, and of these we should like to call attention to the various societies. If the societies are to continue to flourish it is essential that each generation should recognize the usefulness of the societies and their own individual debt to the community. By this we mean that it is the duty of the second years' man to actively support the Physiological, the fourth and fifth year to support the Physical, and the duty of all alike, Residents and Students, to turn up at the Debating Society and the Smokers. If the hospital is to maintain its position it can only be by the subjection of individual tastes to the common weal, and though we feel it the duty of the senior men to discuss medical points, the junior in years, but not in intellect, is not thereby absolved from putting in an appearance.

Every year the Rugby XV. makes its journey (and a very pleasant outing) to Cambridge, and endeavours to uphold our fame at Rugby. For several years past our efforts have been unsuccessful, though last year we deserved to win, and on most occasions we have always given them a good game, our scores contrasting well with those of such well-known clubs as the Harlequins and Rosslyn Park. However, this year we achieved a brilliant victory, satisfactory and decisive, though the elements were completely against our outside play, which won us so much commendation last year. Our congratulations to O'Brien and his men.

All followers of the Rugby game must have noticed that the Blackheath fixture has disappeared. That they should have declined to renew it after a fair beating last year does not argue much for the sportsmanship of the club. It was one of the oldest fixtures on the card, dating, we believe, from the establishment of the Rugby Union, in which Guy's played no inglorious part. It is the more unfortunate, therefore, that Blackheath should have dropped a fixture with an ancient club, and one which, without boasting, would probably have defeated the Heathens this year.

Two years ago the hospital, we believe, against the same adversaries, was in the triumphant position of putting four XV.'s into the field. All returned victorious, while their Soccer colleagues achieved the less arduous but equally meritorious task of returning three unbeaten XI.'s. Last Saturday, *dies Cannensis illa dies*, the Rugby XV.'s were routed in a decisive and alarming fashion. The decline of the 2nd XV. from its proud position is to our mind a very serious thing for the future of the Guy's Rugby Club. Look to 't.

The alteration in the Army Medical arrangements that likes us least is the abolition of Netley, and the consequent transference of the probationary lieutenants to a London hotel, where their mess is now. We cannot but think that whatever arrangements were bad before, it is at the wrong end that improvement has been sought. It would seem possible to turn Netley and Haslar respectively into unique colonial, military and naval hospitals, where the varying types of tropical and other special diseases could be rendered familiar to all the candidates. It seems that with good instruction the clinical material would be unsurpassable, and we are sorry the move was not to improve the teaching and leave the pupils. It should be the case that the accepted candidates are sufficiently grounded in ordinary medicine, and that only the specialities are to be added, and we very much doubt if the present arrangement will work. At any rate, it is not generally approved by those who are working under it.

Guy's Chapel Choir. We hope to be able to announce in our next issue that the choir will shortly commence their duties, and as there are

only a few vacancies we would advise those students who desire to assist, to send in their names to Mr. R. Larkin.

Note.—In our last issue, under the heading of Mr. Henry Taylor's plan for forming Chapel Choir, No. 2 should read—That eight or ten promise to attend the services *one* (*not* "on") Sunday each month during term, &c.

Also—Mr. Henry Taylor's address is 24, *Westwick* Gardens, W., not Warwick Gardens as printed in error in last Gazette.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants in Medical Wards.—Messrs. J. H. Donnell (Dr. Taylor); K. Black (Dr. Hale White); E. W. Strange (Dr. Perry).

Ophthalmic Dressers.—Messrs. G. G. Davidson, E. H. B. Milsom (Mr. Higgens, November 1st); G. S. Robertson, D. W. Smith (Mr. Brailey, November 1st); J. Bromley (Mr. Higgens, December 16th); N. Ivens Spriggs (Mr. Brailey, December 16th).

Surgeons' Dressers.—Messrs. C. D. Pye-Smith, P. P. Cole, M. G. Louisson, H. H. Jenkins, H. F. B. Walker, R. A. Greeves (Mr. Lucas); H. O. M. Beadnell, G. Nunn, R. St. J. Seagrove, A. E. F. Kynaston, J. F. Rey, M. J. Mottram (Mr. Golding-Bird); F. P. Hughes, A. M. Webber, L. H. Frankenberg, E. Lloyd, O. V. Payne, G. A. Ticehurst (Mr. Jacobson); P. A. Peall, H. H. Carter, G. H. Rees, G. C. F. Robinson, R. P. Rowlands, B. H. Stewart (Mr. Symonds).

Dental Surgeon's Dressers.—Messrs. R. D. Smedley (November–December); E. G. Goldie (December–January); A. H. Turner (January–February).

Externs.—F. C. Robinson, R. E. Brayne, P. R. Bolus, H. B. German, J. W. Dadd, C. E. Iredell (November); S. C. Bowle, G. Carlisle, R. Larkin, H. Watts, F. G. Goble, W. T. Meade-King (December); H. Mann, H. D. Smart, F. H. Wallace, A. R. Wilson, E. L. Ward, C. H. Reinhold (January).

Papers by Guy's Men.

Case of Thrombosis of the Cerebral Veins and Sinuses associated with Broncho-Pneumonia. Also

Rheumatic Myocarditis. By Theodore Fisher, M.D.—*British Medical Journal*, 27th September.

Introductory Address at the Opening of the Medical School, University College, Sheffield: The Training of the Student of Medicine. By Sir H. G. Howse.—*Ibid.*, 4th October.

Guy's Hospital Debating Society.

The above Society held its first meeting this session on Saturday, October 18th. The Smoking Room was crowded with men, all eager to welcome the Society's new president, Dr. Savage, who took the chair shortly after eight o'clock, and after a few introductory remarks, called upon the Secretary to read the minutes of the last meeting.

The minutes having been read and confirmed, the sonorous voice of Mr. K. Black made itself heard from the neighbourhood of the "bar" of the House, demanding a reason for the inaccuracy of the Year Book in the matter of the name of the new president, and for the omission in the same of the names of the committee.

This gentleman having been appeased with great difficulty, the Secretary was met by the importunate clamouring of Mr. Thompson for a Ladies' Night on all possible occasions, also by Mr. Collins Lewis' entreaty for an earlier celebration in the session of the same festivity. The chivalrous instincts of these gentlemen were sternly repressed by the Secretary.

Dr. Savage then called upon Mr. P. Blake Odgers to propose "That the Surgeon is of more practical utility to the community than the Physician." The honourable proposer thereupon made an excellent speech from a philosophical point of view, but he seemed prevented from making a forcible statement of his own case by too great a consciousness of the strength of his opponent's. He began by questioning the general propriety of the motion. The surgeon and the physician, he said, were fellow-workers for the public weal, and everything depended upon their efficient co-operation. He then proceeded to warn the House against any monopolisation on the part of the honourable opposer of the laurels of hygiene, vaccination and obstetrics. The sanitary engineer could not be called a physician in any true sense of the word, whilst vaccination (essentially a surgical operation) was, he thought, outside the rightful realm of the physician; obstetrics, too, were in the main surgical. He deplored also the widespread prejudice against the surgeon, so strikingly expressed in a poem of Tennyson's—

> "Fresh from the surgery schools of France and of other lands,
> "With his harsh red hair, big voice, big chest, big merciless hands."

This savoured too much of sentimentalism, which for ever militated against sound and impartial judgment. The rightful practice of surgery tended, in his opinion, towards the "survival of the fittest," it aimed at radical cure, and was not satisfied with mere diagnosis. The surgeon in a great many cases followed up the physician's diagnoses by operation, and if this latter were successful it was to the surgeon pre-eminently that the *kudos* was due. When death appeared to be imminent, surgery, he thought, could often do more than medicine; the physician was too often a mere spectator at the death-bed, perhaps easing the death throes a little, perhaps,

even postponing them, but really incapable of averting the fatal issue. In many medical cases (such as in those of typhoid fever) nursing played so prominent a part that the physician must perforce surrender half the honours to the nurse. He ended by re-asserting his belief in the essential unity of the healing art—but added that if called upon to vote on such a motion as that which was before the House, his opinion was "that the Surgeon was of greater practical utility to the community than the Physician."

The President then called upon Mr. F. R. Bolus to oppose the motion, and the latter gentleman then arose and delivered a fighting speech in vindication of the physician; he was interrupted many times by "rude" and excitable gentlemen in his immediate neighbourhood. The honourable proposer, he said, was not good at thought-reading, for he had no desire to monopolise for the physician either hygiene or vaccination, and certainly not obstetrics—the latter subject he would let severely alone. The "survival of the fittest" was a high-sounding phrase, but it had nothing to do with the subject under discussion. He earnestly begged the House to disregard the spectacular and ornamental attributes of surgery—the pomps and vanities of the operating theatre, and instead, to consider the thousand and one ways in which they, themselves, had been benefited by ordinary medical aid. Did they not remember the abdominal pains of early youth, and how these had been put to flight by the timely administrations of the "kindly physician." The physician served the community assiduously and constantly, sometimes in great things, but more often in small, while the surgeon acquired his reputation by two or three prodigies of operative skill. Was it not better to confer benefits on the many than to confer them on the few. Preventive treatment, unknown in surgery, played an important, nay, a principal part in medicine. The one statue in France erected in honour of the British medical faculty was that of Jenner, the physician, and the apostle of preventive treatment of small-pox. The honourable opposer had sounded the opinion of the community on the subject under discussion. He had sounded a Boro' rough and a maiden aunt (who afterwards played no small part in the discussion). He had found in the community at large a wide-spread feeling in favour of the "dear doctor," the surgeon being not entirely trusted. He then referred to the tremendous dangers of surgery—and spoke mysteriously of appendices sacrificed yearly in large numbers (he did not say whether or no the patients were included in the ceremony). The future of medicine appealed to him; Mayo Robson, of Leeds, having prophesied that in fifty years' time cancer will be in the hands of the physician. Lastly, he mentioned the educative value of the physician to the community, with his power of constantly inculcating the maxims of cleanliness and health. Summing up, he considered that as the physician did more than the surgeon in the way of actual prevention of suffering, he was therefore of greater utility to the community.

The President then addressed the meeting during what he termed the "incubation period" preceding the opening of a general discussion. The debate, he said, was upon the relative merits of surgery and physic, and should not be a comparison of personalities. If we were to refer to history, we should find the barber-surgeon to have been a more useful member of society than the "dealer in charms," but things had developed since then. He noticed a sinister tendency on the part of surgery to encroach upon the domain of medicine, but truly in his opinion, surgery was the handmaiden of medicine. He agreed strongly with the opposer's views on the preventive achievements of medicine, but he emphasised also the rapid and marvellous advances of surgery into the domain of the hitherto impossible. Citing the discoveries of antiseptic surgery, he considered that here medicine must bow the knee to surgery. Surgical paraphernalia so flippantly mentioned by the honourable opposer were the signs of the great advance of that art and should not be treated so disparagingly.

The debate was then opened to general discussion.

Mr. M. A. Collins rose and roundly attacked the honourable opposer's assertion that preventive treatment was unknown to surgery. He cited radical cure for hernia as diminishing cases of strangulation, circumcision as diminishing cases of epithelioma of the penis, and the modern treatment of gonorrhœa as diminishing cases of stricture.

Dr. Eason objected to the use of the word "practical" in the motion before the House. He quoted a eulogy of the physician by Robert Louis Stevenson, to show the opinion of the chronic invalid on the subject under discussion. He also spoke of the importance of the general practitioner as the constant friend and adviser of his patients.

Mr. Collins Lewis then delivered a serio-comic oration. He said that surgery encroached upon medicine because of the incompetence of the physician. The surgeon could be both surgeon and physician, but the double rôle was impossible for the physician. He spoke of the punctuality of the surgeon, instancing the words of a well-known professor at a great London hospital, who "made it a point of honour never to disappoint house-surgeon, dresser, or hospital patient." Then sharply changing the venue, he sneered at the honourable opposer's maiden aunt, recommended the President to take a ride in the surgical lift, and made mysterious references to a certain junior member of the Staff, who, though a family man, insisted upon "sprinting" in the Colonnade.

Mr. K. Black again arose and addressed the House, still from the neighbourhood of the "bar." He presupposed the utter destruction, first of all, of all surgeons and then of all physicians; "in the first case," he dramatically exclaimed, "the death-rate would run up, and in the second, it would fly up. Nature did a lot for us, but," said Mr. Black, "medicine can do much more." We were to remember the horrible plagues and fevers warded off by applied medical knowledge.

Mr. Brayne next arose, amid rounds of applause, and proceeded to emit interesting but disconnected irrelevancies. He did not believe—

(1) In theory (not at any price).
(2) In the torturing of frogs.
(3) In messing his fingers.
(4) In the physician's power to stop pain.
(5) That colds were compatible with exercise (Boro' boxing, for instance).

Mr. Brydone then spoke briefly.

Mr. Thompson then indulged in rasping and uncomplimentary references to parlour-maids, maiden aunts and Boro' roughs as sources of reliable information. He also alluded to the Pentateuch in such a way as to bring tears to the eyes and a reproof to the lips of Mr. Griffin. "When is a surgeon not a surgeon," said Mr. Thompson, and the answer was "When he is operating."

Mr. Glendinning said that in the future, when all physicians shall be psychologists and shall treat both patient and disease—then in those far-off palmy days the surgeon shall be called in, even as to-day we call in "that enterprising toiler, a plumber and his boy."

Mr. Walker, speaking from the point of view of personal origin, pointed out the extreme "utility" of the obstetric physician.

Dr. Spriggs administered a mild and touching rebuke to Mr. Brayne for thinking dirty fingers indispensable to the physiologist. He spoke of the importance to the community of the intellectual productions of many moribund persons, which without the physician's slaying of the forces of dissolution would never have been given to humanity.

Mr. Bolus, in replying, said that the instances mentioned by Mr. Collins did not really prove the exercise of prevention in surgery, as disease was already present in most of those cases. He considered the Boro' rough's testimony of the highest value, and objected to the riddles propounded by his opposers. He also vindicated his maiden aunt's right to respectful treatment. Finally, as a culminating assertion, he declared that in England there was no such thing as the "struggle for existence" mentioned by a previous speaker.

Mr. Blake Odgers then replied. He thought that the honourable opposer must have had an unfortunate experience, if his opinions of the surgeon were as he had stated them. Palliative treatment was certainly in vogue in surgery. There was too much sentiment over the whole question; he again referred to the effecting by surgical means of the "survival of the fittest." If the surgeon could not bring happiness, he could be, and was, of most material use to the body corporate, which perhaps was, speaking generally, at least as good a mission.

The motion was then put to the vote.

For the motion	... ...	42
Against	... ...	33
Motion carried by a majority of		9

Mr. E. H. Griffin, in proposing a vote of thanks to the President, said: The pleasant task of proposing a hearty vote of thanks to you, sir, for coming down here to preside over us this evening, falls to my lot. And in doing so it will not perhaps be amiss if I allude *en passant* to the events which have culminated in your occupying our chair. I cannot deceive myself—nor for the matter of that can I deceive others—that our last session was the success it ought to have been. Several factors led up to this unfortunate climax. First of all we had under the sheltering wing of the society, reared from the eggs of mediocrity, a promising brood of speakers, but before they had had time to essay flights, unkindly fate in the shape of the various examining bodies, snatched them from us. So we suffered from a lack of speakers, and on two occasions, despite the energetic importunities of the secretaries, we were forced to abandon debates because we could find no one to come forward to propose the motions. Our most energetic and popular vice-president, Mr. W. C. C. Pakes, was called away to more lucrative spheres in South Africa, and last of all, Dr. Pavy, the illustrious scientist, who had presided over us since the birth of the society, was forced through ill-health to resign the presidency. From these statements you will see, sir, our society was in a distinctly morbid state. After the resignation of Dr. Pavy the committee found themselves on the horns of a dilemma. They had the mantle of Elijah to dispose of and no Elisha on whose shoulders to throw it. For, sir, we are an intellectual society; we seek here to cultivate and encourage the mental faculties, as opposed to the physical, which latter are catered for by so many clubs. But we do not exclude the "flannelled fool" or "the muddied oaf"; if they wish to cross our sacred threshold we merely expect them to wash the mud from their faces, and to come here clad, not only in the garb of civilization, but also in mental garments woven in the loom of their own genius. I think, then, I have established two facts: that our society appealed to the intellectual, and that it was in a morbid condition. The committee had, therefore, to ask themselves the question, "who can minister to a mind diseased?" To Guy's men the answer to such a question is obvious. We therefore sought and gained your kindly acceptance of the presidential office. The hour is late; I will not detain the House any longer, but propose a hearty vote of thanks to you, sir, for presiding over us this evening. (Loud cheers.)

Dr. Savage spoke of the pleasure he felt in accepting the presidency of the Society. He reminded those who attended his lectures, of his having spoken of alternations in neuroses, of how glycosuria was often followed by insanity; in this case Dr. Pavy was followed by Dr. Savage. He then expressed the hope that he would be able to come down often to preside over the Society's meetings in the coming Session.

Refreshments then terminated a highly successful meeting.

R. E.

Some Thyroids.

In the course of practice I have seen some thyroid cases that, being atypical or very unusual, are, perhaps, worthy of record. The group of symptoms which constitute Graves' disease is very remarkable, and the pathology obscure. Clearly-defined cases are very common, and I have been struck with the tendency which the disease shows to be true to type, so that all the symptoms can be foretold with great certainty. I have observed that the disease has a strong predilection for unmarried young women about their thirtieth year, especially those who have been "disappointed in love" or are the victims of long engagements. Other kinds of protracted nervous strain, as the grinding worry of business anxieties, may produce it. About the hereditary tendency to exophthalmic goitre there can be no doubt; I have twice seen mother and daughter affected. Even elderly men are not exempt. A relative of my own, after a protracted period of financial trouble, developed the disease in a severe form in his sixtieth year. The symptoms have gradually diminished up to the present, when he is in his seventy-second year. A methodist parson of fifty has had a goitre for at least fourteen years. His complaint is that he is getting thinner (emaciation is very frequent) and that he is very nervous. A few days previously he rode a bicycle a long distance to conduct a service. He was seized with a "choking fit," and nearly died—a meagre, anxious-looking man with prominent eyes, a distressing inspiratory stridor, a shaky, nervous manner, and a rapid pulse. The thyroid is symmetrically enlarged, hard, elastic and irregular; there is little doubt that it presses on the trachea. That is to say, symptoms, not very marked, but unequivocal, have supervened on a long-standing goitre.

The next, the case of a woman still under treatment, is of a similar type—a thin, meagre woman of forty-six, with "starting eyes" and a deeply-pigmented skin; the hands tremulous; the pulse very irregular and rapid; the cardiac impulse widely diffused and forcible. The thyroid is enlarged on both sides, but notably on the right. This lobe is hard and smooth, with a clearly-defined outline. She says that it has been enlarged since childhood, and that her mother had the same condition. The left is soft and compressible. The gland pulsates, and the surface veins are very prominent. She has an unceasing, irritable cough. The cough is instantly relieved by flexing the head and thus relaxing the cervical fascia enclosing the gland; the gland itself becomes much less distended, in fact, the left lobe is no longer palpable.

In these two cases we have examples of the combined symptoms of chronic goitre: the one causing pressure on the trachea and stridor; the other, a reflex cough and the classical symptoms of Graves' disease.

Serious errors of refraction are stated to be rare. I have under observation a miserable little woman, a book-binder, with very marked symptoms,—she belongs to the "long engagement" group, who has eight D of myopia. As she has not worn glasses up to the present, it is, I think, fairly safe to conclude that the myopia is a new thing, at least in its present advanced form. As evidencing the dangers of the disease, a girl of five-and-twenty had inherited Graves' disease from her mother who had now recovered, but was dying of cancer. The girl was not seriously ill until one day her heart began to fail, and she died two days later.

In addition, some years ago I published in the *Lancet* an account of two sisters who were deaf mutes and had large hard goitres.

VAUGHAN PENDRED, M.D., F.R.C.S.

Buckingham.

Reviews.

The price of books submitted for review should in every case be stated.

A Handbook of Surface Anatomy and Landmarks. By Bertram Windle, F.R.S. (Lewis, Gower Street.) Price 4s.

Is a correct, dry, anatomical statement which may be relied on, but the head surface marking are not definite enough, and it hardly has a sufficient clinical aspect, *e.g.*, the method recommended of passing a female catheter, *i.e.*, to pass the left forefinger between the labia over the clitoris on to the vestibule, smacks much more of the anatomist that the practitioner.

Artificial Feeding and Food Disorders of Infants. By W. B. Cheadle, M.D., pp. 268. (Smith, Elder & Co.) Price 5s.

There is no section of therapeutics more difficult than the proper treatment of infants in the food disorders which are so common, and at the same time there is no subject which the newly qualified man knows less about. We confidently recommend this work as being thoroughly practical, and at the same time based on scientific principles. The fact that it has run through five editions is also a strong recommendation.

Aids to Dental Anatomy and Physiology. By Arthur S. Underwood, M.R.C.S., L.D.S Eng.; Professor of Dental Surgery at King's College, London: Member of the Board of Examiners in Dental Surgery, Royal College of Surgeons of England, etc.. (Baillierè, Tindall & Cox.) Second Edition. Price 2s. 6d.

This little work has been largely re-written and its form somewhat improved, and the whole brought up to date. Two valuable chapters have been added; one on the development of the mouth, in which is given a clear and homely description of the growth of the mouth and the changes which take place in the jaws before and after birth; the other on the teeth of man and the homologies of the teeth. The chapters on developement of the teeth and calcification are especially clear and simple, and the chapter on practical microscopy is very useful. On the

whole, the work seems to avoid controversy and gives in a clear and straightforward manner sufficient for the beginner to obtain an intelligent grasp of his subject.

A Text Book on Medicine. Begun by the late Charles Hilton Fagge, M.D., F.R.C.P., sometime Physician to Guy's Hospital; completed after his death and since revised or re-written by Philip Henry Pye-Smith, M.D., F.R.S., F.R.C.P.; Consulting Physician to Guy's Hospital. Fourth Edition. (Published by J. & A. Churchill.) Two volumes. Price 42s.

The names of the authors are guarantee sufficient for the quality of the work which is placed before us, so far as the accuracy of detail and plentitude of experience which constitutes the value of such works is concerned; in many other such, however, may these be found, but that which tends to lift the present work to the highest position is the delightful ease and attractiveness of its style.

For those who in reading medicine take delight in having the dry bones clothed in such pleasant garments as the author's plentiful illustrations and historical and etymological notes furnish in this, the fourth edition of his work, the book can certainly not be surpassed. The bare facts are surrounded with that interest, which is so necessary to convert study into pleasure for the majority of men, in a manner which recalls the chief features of Dr. Pye-Smith's clinical work in the wards at Guy's. For those who intend to cram for examinations the book is of course of no value; for those who wish to study medicine it cannot be too strongly recommended. Without being rambling it is discursive and broadly written, and diagnosis is arrived at by wide consideration, not by the jotting down of lists of symptoms of the various probabilities; by experience not by books.

Dr. Pye-Smith, as he explains in the Preface, depends for his statements as much as possible on his own experience, and no better voucher for excellence need be given. His work bears the stamp of authors whose experience of the medicine of the Past is as erudite as that of the Present.

Much obsolete matter which found a place in the last edition has been expunged, and chapters have been rearranged and enlarged.

Of especial value, as might be expected, are the chapters on Affections of the Skin, which are very fully treated, and occupy more than one fifth of the second volume.

A Manual of Surgery. By Rose & Carless. (Ballière, Tindall & Cox.) Price 21s.

The value that the reading public has placed, and we think has rightly placed on this book, may be seen by its rapid and continued sale. It may be said at once that as a general surgery book, especially for the "Conjoint" (a compliment of no mean order) it holds the field to our mind, but there are still several points (quite of minor importance) that we do not consider quite up to date.

Without quibbling it may be said that the reason given for preferring antiseptic surgery to aseptic surgery is rather a weak admission. *Video meliora proboque deteriora sequor.* Surely it is important that the highest standard should be displayed, even at the cost of additional trouble. We still maintain that boiling is *always* the best method of sterilising instruments, and that sterilized *swabs* of whatever material are far more easy to obtain and far more reliable than the more convenient sponge of doubtful sterility. Surgical technique and organisation really make aseptic surgery a comparatively simple method.

Of smaller points the importance and safety of saline irrigation of the abdomen in any doubtful case, and particularly in suppurative peritonitis, does not seem to have been recognised, and a much more gloomy prognosis for the operative treatment of intussusception is given than we are at all inclined to agree with. In fact the weakest point of the book generally is the account and treatment of acute abdominal conditions.

However, it is undoubtedly a valuable and much appreciated work, and the chapter on anæsthetics is full of good practical points.

Notice.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

LICENCE IN DENTAL SURGERY.

Old Regulations.

Notice is hereby given that the next examination will commence on Friday, November 7th, 1902.

New Regulations.

Notice is hereby given that the First Professional Examination will commence on Friday, November 7th, 1902. Candidates are required to give not less than twenty-one clear days' notice in writing of their desire to present themselves for either of these examinations to the secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, W.C., from whom all particulars relating thereto may be obtained.

September 23rd, 1902.

Bath.—The following Guy's men are members of the Medical Committee which has been formed to advise the Corporation respecting the Baths and Bathing Establishments: E. Field, M.D., A. E. Norburn, M.D., T. D. Ransford, F.R.C.S., R. J. Scott, F.R.C.S. Edin., T. Wilson Smith, M.D.

"The Art of Prescribing," in the *Westminster Hospital Gazette*, is an amusing article, from which we quote some terse sayings, which remind us of the Golden Rules of Surgical Practice:—"In prescribing as in domestic life it is well to avoid incompatibilities." "The person who habitually uses compound tincture of lavender will never have a good class practice, and will always be dressed by a third-rate tailor." "It does not follow that a man is leading an immoral life because he cannot write Greek verse."

Sport.

Rugby Football.

GUY'S v. LENNOX.

This match was played at Stamford Bridge on Saturday, October 11th, and, though somewhat wild, a good game resulted in a win for Guy's by 8 points to 3.

In the absence of Morgan, Payne and Louisson we were not at full strength. Lennox started with a strong wind behind them, and after a lot of loose play scored a somewhat lucky try before the game had been going on ten minutes. On resuming, Alcock put in a good run, but was grassed near the line, and Lennox, in turn, invaded. Play was rather loose and confined chiefly to the forwards, and a forward pass robbed Lennox of a chance of scoring. Our front division then settled down, and time and again bustled the opposing three-quarters in fine style. Half-time arrived with Lennox leading by 1 try to nil.

In the second half, Guy's did most of the pressing. Alcock put in another good run, but failed to get over. Persisting in the attack, Guy's were soon rewarded, as, after a smart run by O'Brien, who transferred to McEvedy, the latter dashed over the line and scored. O'Brien placed a beautiful goal. Still keeping up the pressure, after a short time Alcock got through, and going right round, scored under the posts. Somehow or other, O'Brien failed with the kick. Time was called with Guy's still pressing. Team:—

Guy's.—E. M. Harrison (back); A. O'Brien, P. F. McEvedy, F. Alcock, C. D. Pye-Smith (three-quarters); R. Willan, R. W. Allen (halves); R. G. Anderson, B. Glendinning, E. L. Ward, A. R. Thompson, E. H. Milsom, S. M. Saunders, A. M. Tolhurst, T. B. Layton (forwards).

GUY'S v. CAMBRIDGE UNIVERSITY.

This match was played at Cambridge, on Wednesday, October 15th, and resulted in a win for Guy's by 1 goal and 1 try to nil.

It was an awful day, the rain coming down in sheets as the players entered the field, and, at the start, Guy's kicked off against a strong cross wind. The 'Varsity started well, and for the first ten minutes pushed us about a bit. However, this did not last long, as the Guy's forwards soon settled down to their work in good style, and fairly ran round the opposing pack. Twelve minutes from the start, O'Brien made a good opening, and handing the ball on to Morgan, the latter scored far out. O'Brien's kick failed. Soon after this, M. C. Wetherell was injured and left the field, but despite this misfortune Guy's continued to have the upper hand, and at half-time led by a try to nil.

Wetherell came back after the interval, and in the second half the combination of the Guy's outside was far better than their opponents. Saunders nearly scored in the corner, and after Cambridge had touched down twice, a good piece of play by O'Brien and Morgan resulted in the latter dashing through and scoring a grand try, which he converted with a fine kick. Nothing further was scored, and Guy's left the field winners as stated. Team:—

Guy's.—E. M. Harrison (back); E. Morgan, A. O'Brien, P. F. McEvedy, F. Alcock (three-quarters); F. C. and M. C. Wetherell (half-backs); R. G. Anderson, B. Glendinning, E. L. Ward, A. R. Thompson, E. H. Milsom, S. M. Saunders, A. M. Tolhurst, T. B. Layton (forwards). Referee: Mr. C. T. Scott.

GUY'S v. CATFORD BRIDGE.

Played at Honor Oak, Saturday, October 18th, before a fair gathering.

The weather was rather unfavourable to good football, but not sufficiently so to justify the most disappointing display given by Guy's; judging by the results of the Cambridge match, much better things were anticipated. Anderson kicked off for Guy's twenty-five minutes after the advertised time. Walmsley returned, and McEvedy found touch. Some scrimmages and loose play followed, our forwards holding their own in the scrums and letting out the ball, but several opportunities were lost owing to bad passing, the halves failing to get the ball away cleanly to the three-quarters. The game was worked into the Catford territory, and after a round of passing, Morgan tried a drop at goal, which failed, and Catford touched down. The game was again brought into Catford twenty-five by a good kick from McEvedy into touch near the goal line. Catford, however, soon worked the game back. Pinching made a useful dribble, and Glendinning brought off a good kick. The referee shortly afterwards awarded a free kick to Catford, which fell wide. In a few minutes another free kick was given to Catford for "foot up," this time going nearer the mark and hitting the cross-bar, but failing to go over. Catford then made a determined attack, and the ball was brought over our line, but Glendinning touched down. After some loose play, a free kick was awarded to Guy's for off-side. The ball was then dribbled over the Catford line, but Wetherell failed to touch it down. Play returned to half-way, and shortly after the whistle sounded for half-time, nothing having been scored on either side.

Soon after re-starting, it was noticed that the Catford men were playing with greater dash than our forwards and getting the ball more frequently. Another free kick was awarded to Catford for "foot up." On our three-quarter getting the ball there was a good round of passing, and Morgan was stopped by the full back. The game was brought back to the middle of the field, and an unaccountable free kick (the fourth) was given Catford, and Helder this time landed a goal. Some loose play followed. A free kick was awarded to Guy's and then to Catford. A kick from their three-quarters going into

touch after touching one of our men, was thrown out by Catford, who scored a try which was not improved on. A few minutes later Catford scored again from a forward rush and kicked a goal. After kicking off, the ball was forced into Catford twenty-five, and Morgan made another effort to score, but was collared. Catford forwards brought the game back to the middle of the field. Pinching made another useful dribble. Catford again looked dangerous owing to Harrison failing to get in his kick, and on the call of time stood winners by 1 penalty goal 1 goal and 1 try—11 points—to nil.

Remarks.—Catford played with greater dash than our men, and their collaring was better, and to this and our poor exhibition at half they owe their victory. Of the new men, Pinching and Saunders were the best, Pinching putting in two good dribbles and collaring well. Three of the forwards were in very poor form. Harder work in the scrums, better collaring and more dash are wanted all round. The ball came out in our own twenty-five too often. We were also penalized for "foot up" on several occasions. Halves were very poor, and it would have made all the difference in the result if the ball had been passed out cleanly to the three-quarters in the first half when we were holding the scrums and getting the ball. McEvedy, O'Brien and Harrison got in some very good kicks, but the collaring was consistently poor, and the style was not one that gives confidence, most attempts being far too high—a dangerous error.

GUY'S 3rd XV. v. MERCHANT TAYLORS' SCHOOL 2nd XV.

This match was played at Bellingham on Wednesday, October 8th, resulting in a win for Guy's by 3 goals and 6 tries (33 points) to nil. The following scored tries:—G. Wacher 5, Edsall 1, Bookless 1, Gibson 1, Metcalfe 1. Team:—

Guy's.—Marshall (back); Bookless, Gibson, G. Wacher, Edsall (three-quarters); Myott, T. R. Harvey (half-backs); Metcalfe, Doudney, Ball, D. Reynolds, Barton, Helm, L. Reynolds (forwards).

GUY'S 3rd XV. v. KING'S COLLEGE ENGINEERS 2nd XV.

This match was played at Wormwood Scrubs on Saturday, October 18th, resulting in a win for Guy's by 1 penalty goal and 2 tries (9 points) to 1 goal and 1 try (8 points). Metcalfe opened the score for Guy's by a successful free kick from the touch-line. T. R. Harvey scored twice in last fifteen minutes. Husbands played a good game at back. Team:—

Guy's.—Husbands (back); Wight, Watson, Edsall, Gibson (three-quarters); T. R. Harvey, Whittell (half-backs); Metcalfe, C. P. Harvey, D. Reynolds, Pallant, Helm, Myer, Marshall, L. Reynolds (forwards).

Association Football.

GUY'S HOSPITAL 1st XI. v. GUILDFORD.

This match was played at Guildford on Saturday, October 18th, and resulted in a win for the hospital by 5 goals to 1.

Guy's lost the toss, and kicked off against the wind. After some mid-field play, our forwards took the ball up to our opponents' goal, and the ball coming out, Denning scored with a good shot in the corner. Shortly afterwards Barber added a second. This was the score at half-time. On re-starting, Guy's at once showed their superiority, and the opposing defence was severely tried. Litchfield scored our third goal after a fine run. Barber added a fourth soon after, and had hard luck in being given off-side, when he had shot fifth. Guildford then scored by means of their inside left. Norton scored again for Guy's, and time found them attacking strongly.

The forwards have seldom played better together, Barber, Wragg and Litchfield being especially conspicuous. Zorab, at half, was very safe, and fed his forwards judiciously. Team:—

Guys.—E. A. Collins (goal); A. Leeming and A. G. Jones (backs); A. Zorab, A. F. Denning and P. Pedrick (half-backs); E. Wragg, P. C. Litchfield, H. Barber, E. L. R. Norton and G. F. Fothergill (forwards).

GUY'S 2nd XI. v. WOODFORD ALBION (Away).

The ground was very heavy and encumbered with freshly-mown grass, but in spite of this the game was fairly fast.

Guy's won the toss, and had the advantage of a slope and breeze. Woodford settled down quicker and were first to score, but Littlejohns equalised from a corner, well taken by Scales. Barlow improved our position by scoring twice with good shots before half-time.

In the second half Woodford pressed almost continuously, and though assisted by a penalty kick, could only score once. Jones, Berry and Turner were especially good in defence.

From a break-away Littlejohns scored with a well-placed shot. A pleasant game ended in a win for Guy's by 4 goals to 2. Team:—

Guy's.—E. H. B. Turner (goal); A. Leeming and A. G. Jones (backs); —. Scales, H. Berry and —. Poyce-Davies (half-backs); J. B. Harland, S. H. Barlow, W. H. Miller, A. S. Littlejohns and T. F. Wilson (forwards).

United Hospitals Hare and Hounds.

The above club appears to be almost unknown to many Guy's men, especially freshmen. It was founded in 1886, and has existed since then with varying success. Guy's held the Inter-Hospital Cup from 1892 to 1900 inclusive, when St. Thomas's took it from us, to lose it in turn to St. Bartholomew's last season, and if Guy's

ever wish to regain that cup they will have to do a great deal more to support the club.

Last season the team successfully ran against Thames Hare and Hounds and Dublin University Harriers, but lost badly to the Ranelagh Harriers. This season, in addition to those three clubs, we have fixtures with Oxford, Cambridge, Blackheath, South London, Wellington College, Lancing and Sandhurst, and it is essential that the team should be fully representative if we are to meet with anything like success.

The Blackheath Harriers, second only to the Thames Hare and Hounds in point of age, have once again most kindly placed their capital rooms and trainer at our disposal, free of all charge, with full permission to join any one of their packs, fast, medium or slow, and stay on to their dinners and smokers after the runs, should the men so desire, giving us every benefit that a member of their own club enjoys without necessarily expecting us to join their club; and as their headquarters, "The Green Man Hotel," Blackheath Hill, is so very handy for the majority of Guy's men, it would only be a matter of courtesy to Blackheath for as many men to turn out as possible.

The slow pack starts soon after 3 p.m. every Saturday. The fixtures at present arranged are:—

Wellington College	Oct. 25th
South London Harriers ...	Nov. 8th
Blackheath Harriers	Dec. 6th
Ranelagh Harriers	Jan. 17th
Thames H. & H.	Jan. 31st
Cambridge University H. & H.	Feb. 7th
Oxford University H. & H. ...	Feb. 14th
Dublin University Harriers ...	Feb. 21st

Inter-Hospital Cup, probably Feb. 25th.

Appointments.

CIVIL.

Brodrick, C. C., L.R.C.P., L.R.C.S. Edin., has been reappointed Medical Officer of Health to the Tavistock Rural District Council.

Duffett, H. A., F.R.C.S. Eng., has been appointed Medical Officer to the Greenwich Union Childrens' Home, Half-Way Street, New Eltham.

Harnett, Charles John, M.D. Lond., M.R.C.S. Eng., L.R.C.P., has been appointed Surgeon and Agent to the Admiralty at Margate.

Ingram, Percy Cecil Parker, L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer to St. Saviour's Union Infirmary, East Dulwich.

Jones, R. Orford, L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., has been appointed Admiralty Surgeon and Agent for the Torcross and Hallsands District; also Trinity House Medical Officer to the Start Lighthouse.

Morrison, J. T. F., M.A. Camb., M.Sc. Birm., F.R.C.S. Eng., has been elected Honorary Surgeon to the Queen's Hospital, Birmingham, *vice* F. Marsh, F.R.C.S. Eng., resigned.

Roberts, W. O., L.R.C.P. Eng., M.R.C.S., has been appointed Assistant Medical Officer to the County Lunatic Asylum, Lancaster.

NAVAL AND MILITARY.

Surgeon R. W. B. Hall, R.N., has been appointed to the *Resolution*, and Surgeon J. C. G. Reed, R.N., to the *Medea*.

Surgeon F. C. Stearn, R.N., has been appointed to the *Vernon* for the *Jaseur*.

Surgeon-Captain H. P. Berry, 2nd Volunteer Battalion the Lincolnshire Regiment, is promoted to be Surgeon-Major.

Surgeon-Captain R. H. Luce, from the 1st Volunteer Battalion the Derbyshire Regiment, to be Surgeon-Captain in the Volunteer Infantry Brigade Bearer Company, Sherwood Foresters, and to command under paragraph 55a, Volunteer Regulations.

Medical Department of the Navy,
Admiralty,
Northumberland Avenue, W.C.
6th October, 1902.

An Examination of Candidates for entry into the Medical Department of the Royal Navy will be held on the 17th November next and following days at Examination Hall, Thames Embankment. Not less than Thirty-five Commissions, as Surgeon, will be offered for competition.

The forms to be filled up by candidates will be supplied on application to this Department.

H. F. NORBURY, Director General.

From the Gazette's Special Pathologist.

H.A.C., Saxmundham.—This sputum was almost non-purulent, but the tubercle bacillus was found in small numbers. PATHOLOGIST.

Births.

CALDECOTT.—On October 4th, the wife of Charles Caldecott, M.B., B.S. Lond., M.R.C.S., Medical Superintendent of the Earlswood Asylum, Redhill, Surrey, of a son.

TA'BOIS.—On October 9th, at 2, Mornington Villas, Woodford Green, Essex, the wife of Frederick William Ta'Bois, L.D.S. Eng., of a son.

Death.

SAMPSON.—On September 10th, at Shirley, Southampton, James King Sampson, F.R.C.S., aged 85

Ed.—J. M. B.

Contents.

	PAGE
The Medical Profession	449–451
On Thoracic Aneurysm: Clinical lecture by Dr. Hale White	451–457
Correspondence: South African Memorial; Gazette ...	458
Guy's Hospital Physical Society	458
Washbourn Memorial Fund: 2nd List	458
Passim	459–460
Three Cæsarian Sections	460–462
The "Contemporaries" Club...	462
Obituary	462
Guy's Hospital Dental Society	463–464
University of Cambridge	464–465
Guy's Hospital Students' Club	465
Reviews	466
Examining Board in England	466–467
Sport: Rugby Football—Guy's 2nd XV. v. Croydon "A"; Guy's 3rd XV. v. Kensington 3rd XV.; Guy's 3rd XV. v. Kensington 3rd XV. Association Football—Guy's v. Surbiton Hill. Inter-Hospital Association Football Club. Guy's Hospital Hare and Hounds	467–468

Calendar of Coming Events.

Nov., 1902.

Sat. 8.—1 p.m., Clinical lecture by Dr. Hale White.
Messrs. Symonds and Steward's take-in; Drs., G. C. F. Robinson and G. H. Rees; Cl., A. H. E. Wall.
G.H.R.F.C., II., Rosslyn Park II., home.
III., Old Charltonians "A," away.
G.H.A.F.C., I., Ipswich Town, away.
II., Parthians, home.

Mon. 10.—1.15 p.m., Clinical lecture by Mr. Brailey.

Tues. 11.—Last day for applying to Registrar for Form of Entry for B.S. Lond.
Cambridge 3rd M.S. Schedule to be brought to Medical School Office for signature.

Wed. 12.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., III., Dulwich College II., away.
G.H.A.F.C., I., Felstead, away.

Thur. 13.—Messrs. Lucas and Lane's take-in; Drs., R. A. Greaves and H. H. Jenkins; Cl., M. J. Rees.

Fri. 14.—4 p.m., Meeting of the Dental Society.

Sat. 15.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Bedford, away.
II., Beckenham, home.
IV., Court Hill "A," away.
G.H.A.F.C., I., Weybridge, away.
II., Surbiton Hill II., away.

Mon. 17.—1.15 p.m., Clinical lecture by Mr. Steward.

Wed. 19.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.P.P.S., Pathological Meeting.
G.H.R.F.C., IV., Dulwich III., away.

Thur. 20.—Messrs. Golding-Bird and Dunn's take-in; Drs., G. Nunn and M. J. Mottram; Cl., F. H. Parker.

Sat. 22.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Old Merchant Taylors, home.
III., Wasps III., away.
G.H.A.F.C., II., Reigate Priory II., away.

Guy's Hospital Gazette,

NOVEMBER 8, 1902.

The Medical Profession.

By the courtesy of the Editor of the *Guardian* we have been enabled to peruse an article (one of a series) on the medical profession as a career.

It is quite unnecessary to say that such articles may do much towards determining the anxious parent to fix on medicine as a career for a son or a daughter (though the latter point is ignored), nor is it necessary to add that nothing is more difficult or important than to know how to decide an opening in life for schoolboys.

But in medicine it is obviously a matter of great importance that unsuitable candidates should not be started, for two reasons. A weak candidate in law will, if qualified, do but a limited amount of damage, but the ignorance of a doctor may entail, and alas does, livelong disability on his unfortunate and unsuspecting patient.

In this connection it may be noted that the medical finals are oftener fatal (in its classical sense) to candidates than the final stages of any other profession. Many a man has accomplished much to fall out near the finish, though some qualification may usually be attained in the present day by almost anyone who will persevere, and, per contra, it is notorious that the industrious "chronic" usually develops into a successful practitioner.

There is a very great and striking difference between the medical entry and the qualified output, in the "higher exams.," that is to say, and this is well marked in the Cambridge degrees, rather more in the Fellowship, and rather less in the London degrees, and this is a point that many a man has overlooked and thereby wasted many years of profitless study, in striving after degrees that his industries ill adapt him for.

Two essentials are considered, diligence and aptitude; we would agree with both but emphasise the advantages of a keen knowledge of the world and a kind heart, qualities often summed up in the expressive term "bluff."

The motives that deter would-be doctors are as elsewhere mixed and varied. The disadvantages from a cold and dispassionate view are chiefly the length of the course, the considerable expense, and the hard work of the probation and the unceasing labour of the medical man.

It must be admitted that hard and unending labour is the lot alike of consultants and general practitioners to a degree that the public often little realise, from familiarity with it in the case of the local doctor and from incredulity often in the case of the famous hospital physicians and surgeons.

The writer states without much qualification the length of the course to be five years, with a year's post graduate work, and the expenses apart from board, etc., at £230, and for the "Conjoint" and "London" together £300.

Both these sin seriously by understating the case. Few but army, naval, or Indian medicals, a small proportion of the whole, leave the hospital five years after they enter it, and in all the expense is considerably more.

We should prefer to put the lowest expense at £150 for six years, and even this means a considerable seclusion and great economy in many of the average student's pastimes. It is often far greater, and we believe the average expense of the London man living in lodgings and taking an average part in the life of the hospital, and keeping himself as a gentleman's son, must be put at £160 a year at least, and more often it exceeds that, including his fees. Compare this with a lawyer who pays £380 to £400 down for his articles and stamp duties, lives usually at home for all but his last year or two of Articles, when his expenses are only the same as his medical brother.

We should be inclined to say that never before has the medical student been so well allowanced or cost his parents so much as at the present day, and the evidence is not far to seek, viz., the increased entries at Cambridge of men of below average ability, also the length of time many men are contented to spend on their education, though we would maintain that the additional expense is usually quite wise. Nor is the reason of the increased expenditure hard to seek. Living in London is expensive and on the increase, fees are generally rising, extra classes are constantly required, examinations arduous, and rejection involves a considerable pecuniary penalty; occasionally rejections are as high as 50 per cent. But chiefest of all is the fact that the influx of sons of a wealthier class has forced up here as in the Army and in Society itself the average standard of necessary expenditure.

We believe the average time that the Cambridge undergraduate takes to obtain the M.B. is between seven and nine years, and the average time that has elapsed between the entry of the student and his exit after completing his term as Resident and his higher examinations would probably surprise many who talk glibly about a five years' course with a year more for Higher Examinations.

Further criticisms would be that the fees outside of the general practitioner are slightly higher, but the loss of the unqualified assistant has made the practitioner's life correspondingly more arduous.

We are inclined, after careful consideration, to put the average length of Conjoint study at six years, and of the "London" and Fellowship at seven years, and that the expenses vary between £600 and £1000 for the average man who is not living in lodgings or in the college.

The average prosperous upper middle-class gentleman or army man, may reasonably expect that his son's medical education will begin at 18 to 19, last six years or seven, cost £1000 to £1200 if he is to be self-supporting without home living, and that he will then have to pay two and a half to three times the value of the *net* income to buy a practice. The path of the consultant is more thorny and also more risky.

Against the above facts and the undeniable hard and constant study we would set the facts that it is a "hobby" in addition to a livelihood, and that there is no profession more interesting or engrossing.

And yet again, against this absorbing human interest we must put the certainty of only £160 a year after qualification, though we should imagine the average decent class practice varied between £400 and £700, out of which, however,

he has to support a social position representing larger means and entailing relatively greater expenditure.

Still to *suitable* candidates we still hold it to be the finest profession and most likely to ensure their happiness in life.

On Thoracic Aneurysm.

CLINICAL LECTURE BY Dr. HALE WHITE.

October 18th, 1902.

GENTLEMEN,—It chances that during the last six months I have seen seven cases which either proved on post-mortem examination, or we thought during life, to be examples of thoracic aneurysm, so I thought we might consider them to-day because I am sure we shall be able to show you before the hour is over that this is a subject well worthy of consideration on account of the numerous difficulties which often arise. The first point about these seven cases to which I would direct your attention is, that in four out of the seven the pulmonary signs were of great interest. So, to begin with, let us take these pulmonary signs. I will first give you the pulmonary signs in No. 163. He was a man æt. 38, who came into Philip, in number 7 bed, on the 15th April this year under my care. The report says, that "In October, 1901, the patient noticed that his breathing became very uneasy. He had been subject to fits of coughing for about twelve months previous to this. The sputum has been examined for tubercle bacilli, but none have been found. The right side of the chest moves better than the left. There is no entry of air on the left side which is resonant but the voice signs are deficient, and the tactile vocal fremitus is diminished." In another case the signs were these,—"The air entry on the left side behind was deficient at the lower part." Then in the third out of the four cases, a man who now lies in No. 9 bed, in John ward, we notice that "The air entry behind on the left side is deficient below. The left side of the chest has fallen in. The measurement is fifteen and a half inches on the left and sixteen and a half on the right. It moves badly when the man draws a deep breath, and over the left lower lobe there is dulness, bronchial breathing, pectoriloquy, and some consonating râles." What strikes us very forcibly about the case is that these physical signs are limited to the left lower lobe. You can correctly map it out on the man's chest by the physical signs that I have mentioned. The fourth case I want to draw your attention to on account of the pulmonary signs, is a woman now in Miriam, in No. 29 bed. The pulmonary signs about her are that she has a violent brassy cough, and many râles and rhonchi over both sides, and there is striking deficiency in the air entry at the right base. I ought to have mentioned that the man in John has also hæmoptysis.

Now you will notice that the common points about all these four patients—two in Philip and two in Clinical—is, that there is deficient entry of air confined to one lung, or to a part of the lung. That is most important. All of us in health get our air equally into the two sides. We better therefore consider what are the causes of deficient entry of air into the lung. By that we mean the local deficiency with regard to one lung. We cannot go over the many causes of deficiency of air entry into both lungs. For instance, emphysema leads to deficiency of air entry into both lungs; pressure on the trachea leads to deficiency of air entry into both lungs. We put all these aside and come to the investigation of the cases in which there is deficiency of air entry into one lung or part of a lung. Taking, first of all, outside the lung, as you know, either pleuritic effusion, pleurisy, or thickened pleura will certainly lead to deficient entry of air on the affected side. But we need not go into this now. I need hardly tell you that we have been over all our patients to see whether they have got pleurisy or pleuritic effusion, and there is no evidence, and we do not suppose that the deficient entry of air is due to these. Naturally the next thing to think of in regard to deficient entry of air, as the most obvious cause, is that there is some obstruction of the bronchus, and such cases are difficult and require much judgment to discriminate them. Let us think what may be the effects of obstruction of the bronchus. In the first place, the patient will certainly be short of breath, so that one result of obstructing a bronchus is dyspnœa.

Then the chest will certainly move less freely upon the affected side of the chest than on the other. There will thus be impaired movement of the chest, and, obviously, the bronchus being obstructed there will be impaired entry of air. Then there is a result which men very frequently forget in examining such cases—the impaired entry of air leads to collapse of the lung. The reason is that if the air cannot pass in and out equally, the air retained in the lung becomes absorbed and so gradually the lung collapses. Then you know it is a pathological fact that if the lung collapse, gradually the collapsed lung becomes fibrous. The result of this collapse of the lung and fibrosis is naturally that the chest falls in on the side on which this has occurred. In the case of the man in John ward, his chest has fallen in on the left side we believe in this way. His lung has first collapsed, and then the collapsed tissue has become fibrous. The next effect is that the bronchial tubes dilate. That, I may mention, in passing, is extraordinary to a beginner. I am quite sure that if any of you who do not know, were guessing at an examination you would not readily guess that this obstruction of the entry of air into the bronchial tubes would cause them to dilate, you would say, "for them to dilate more air should pass into them." But remember the fact that impaired entry of air causes the bronchial tubes to dilate. The main reason is probably that, owing to the obstruction, the secretions in the tubes cannot be coughed up properly and they are retained, and if retained they must necessarily decompose, and the decomposition sets up some inflammation of the bronchial tube. There was a post-mortem not long ago in a case of dilated bronchial tubes where you could see the sub-acute inflammation of the tubes. The tubes become inflamed and as a result their wall is weakened, and so they dilate and the dilatation is added to by the effect of the coughing, because owing to the coughing there is a closed glottis, and when the attempt is made to cough, the air cannot get past the closed glottis, and therefore the pressure in the tubes is raised and the bronchial tubes therefore dilate. So that the decomposition of the secretions and the coughing lead to the tube becoming dilated. Then a later cause for the dilatation is that when the fibrous tissue has formed the contraction of it will lead to dilatation of the tubes.

Well then, of course, as these retained products within the bronchial tubes decompose, sooner or later the collapsed fibrous lung becomes septic, and it is well known that one of the commonest affections due to obstruction of the bronchial tubes is septic pneumonia. That may go on until the lung becomes actually gangrenous. To show you that this is not all made up, let me read to you a report of one of our cases that died. In the post-mortem report you will see that this man, who had an obstruction to one of his bronchi, presented at the post-mortem just the kind of lung which I have been telling you will occur. Dr. Bryant made the post-mortem and he has written down this: "There was recent pleurisy affecting the posterior and outer part of the whole of the left lower lobe. The whole of the lower lobe was solid and tough from fibrosis and chronic pneumonia and the bronchial tubes were much dilated and filled with a greenish-yellow muco-pus. There were also a few areas of septic broncho-pneumonia. The cause of the bronchiectasis was a sacculated aneurysm of the descending thoracic aorta, which involved the branch of the bronchus which went to the lower lobe."

Clearly the next thing that we have to do, in connection with these cases, is to try and think what things will block a bronchus. The first cause, and the commonest, is that sputum will block it, and this accounts for many cases in which, say, A listens to a lung and finds physical signs which B fails to find later. Generally the reason is that some expectoration has blocked a bronchus, and this accounts for the difference in the signs. It is notorious how largely the signs of phthisis differ from day to day. Often that is due to blocking of bronchi, but this is not important in connection with our patients, for the block was permanent.

The next cause you would naturally give for blocking of a bronchus is a foreign body in it. At any moment you may be called upon to deal with this condition, and therefore the recognition of it is most important. Here is an admirable

specimen (shown) from our museum, in which a pea has blocked the bronchus. You can see the pea lying in the bronchus, and the lung below is tough-looking and fibrous, and the tubes are dilated just exactly as we have already seen would occur when a bronchus is blocked. Let me relate an actual case to illustrate what you may expect when a bronchus is stopped. I got a very urgent message from a doctor to come at once and see a patient; I went and found a surgeon was already there; he had been sent for at the same time. It appeared that two or three hours before I saw the man, he had been having an anæsthetic for the removal of a tooth, and the dentist had let the tooth go unfortunately while the patient was under the anæsthetic and there was considerable doubt as to what had become of the tooth, but it had certainly gone down either the œsophagus or the trachea. We went over the patient and it appeared to one of us that on the left side corresponding to the bronchus going to the left lower lobe, the entry of air was not quite so good as on the other side, and there appeared also to be just a little dulness, very slight, over the left lower lobe. From those signs one of us ventured to put himself in a minority in saying that the tooth was in a bronchus because the other two thought the man had swallowed it. The one who said he thought the tooth was blocking a bronchial tube considered he was right in the suspicion because he had found dulness, which was probably due to the fact that already a little collapse of lung had occurred, and he believed that the deficient entry of air and impaired movement that was also noticed resulted from the fact that the tooth was not completely but partially blocking the left lower bronchus. The majority said those signs seem to us so slight that we should have thought that they were within the boundaries of health. We cannot help thinking that they are trivial, but if one of us thinks the tooth is in a bronchus, it is quite clear that the man must not be left, for the probability is that the patient will suddenly cough up the tooth, and then it may get impacted in the larynx and he may die suddenly before help arrives. It was arranged that the doctor who was in charge should sleep in the patient's room and have tracheotomy instruments handy. About two o'clock in the morning the doctor heard the patient cough, and jumped out of bed, not knowing what might happen, and just as he got to the patient's side the patient coughed out the tooth. It was perfectly clear that it had been in the lung because he coughed it out, and next morning the slight signs had disappeared. There is nothing like a tale for fixing facts upon you. I was much interested in the subject, because about the same time there was a child under Mr. Durham that I saw. The child had got down into its lungs a nib, and the case illustrated admirably the signs of a blocked bronchus by a foreign body, for one day when you went over the lung you could notice a little impaired entry of air and dulness, such as you get in the early stage, and the next day you noticed just the same signs on the other side and the previous side had become healthy. What happened was that the child had coughed up the nib as far as the trachea, and then the nib had gone down another bronchus. There was never a surgeon more dexterous than Mr. Durham with his hands. He had previously fished up foreign bodies from bronchi and in this case he opened the trachea as low as he could and tried hard to fish up the nib, but failed. The child went out of the hospital, and had not been out a day before it coughed up the nib, and from that day it got quite well. A foreign body, then, such as you see in this specimen (shown) is a very important cause of obstruction to a bronchus.

The next cause that I will mention to you—we are very fortunate in having a specimen in Guy's Museum, and we owe it to a Guy's man, Mr. Wilkinson King, who described it in the first volume of the Guy's Reports nearly seventy years ago, viz., in 1838—is pressure on the left bronchus by the dilated left auricle. In severe cases of heart disease occasionally the dilated left auricle presses on the bronchus, but this is quite exceptional. Personally I have never seen it, Dr. Fagge had never seen it either.

The next cause is also very rare, namely tubercular bronchial glands will sometimes press on the bronchus. Then abscess in the chest might press upon the bronchus. Very rarely carcinoma

of the œsophagus will do it; that is important to remember, because carcinoma of the œsophagus is common, and yet if you see a patient in whom carcinoma of the œsophagus is suspected and the bronchus is pressed upon, you should say that the diagnosis of carcinoma of the œsophagus is probably incorrect, so rarely does it occur. Then primary growth in the bronchus may obstruct it, but it is very rare. I have mentioned to you several rare causes, and have left the commonest causes to the last.

The common causes of obstruction to a bronchus are: syphilitic ulceration, malignant growth outside, and aneurysm. With regard to syphilitic ulceration, it will not, I think, apply to any of our cases here, because, probably, syphilitic ulceration is never lower than the bifurcation of the trachea. You should, however, remember that it is by no means uncommon and may tax one's diagnostic powers to the utmost, but you see, being at the bifurcation it will either impair the entry to both lungs, both the right and left bronchus being affected at the bifurcation of the trachea; or it will impair the entry of air to the whole of one lung from one bronchus only being implicated and it will not cause impairment of entry over only part of a lung as in our four cases. We have, therefore, only two causes left, growth or aneurysm pressing on a bronchus. We will now discuss these two and see which of them was probably the cause of the trouble in our cases. Case 163 died and an aneurysm was found, so that there was no doubt as to what was the cause there. Unfortunately the specimen was thrown away, but I bring one from the museum to show you the sort of thing. However, in this specimen the aneurysm you see presses on the whole of the left bronchus and so impaired the entry of air to the whole of the lung. In our case it was a branch going to the lower lobe that was mostly pressed upon. In the next case, in Philip, we took the patient down to Mr. Shenton, and we saw the aneurysm pulsating on the screen, so that in neither of these cases was there any question as to diagnosis.

The remaining two are now in the Clinical wards. With regard to the woman in No. 9 bed, the evidence is very strongly in favour of aneurysm. It consists in this. In the first place, Mr. Shenton thinks he can see the aneurysm. The only objection to this belief is that when seen on the screen, what appears to be the aneurysm, does not pulsate. But you see in this radiograph there certainly seems to be something there (indicated) which looks as though it must be an aneurysm. You see this great mass to the side. That radiograph is in itself very strong evidence. But it is not the only evidence in her case. She has a brassy cough, and although a brassy cough is not pathognomic, it is strong evidence of an aneurysm. She has such a typical brassy cough that if any of you have a phonograph you ought to take it down for demonstration purposes afterwards. It is the most typical cough, I think, I ever heard. In the next place, she has pain. Further, she has some dulness in the second right intercostal space, just where the arch frequently gives way if there is going to be an aneurysm, because it receives the impulse of the blood thrown out from the left ventricle. She has also got over her aortic valves to-and-fro murmurs, which strongly suggest aortic obstruction and regurgitation due to some atheromatous change in her aortic valves, or the same change in the aorta just above, and there is nothing therefore more likely than that she has also got atheromatous change in the aorta with the formation of an aneurysm in such a place that it would lead to impaired entry of air to the left lower lobe of the lung. So that although aneurysm is so very rare in women, being nine to one in men against women, yet I think that the diagnosis of aneurysm is probably correct.

We are not, however, in nearly as good a position with regard to the man in John ward. I frankly do not know what is the matter with him and nothing is more interesting than to discuss what it can be. First, he has got obstruction to the entry of air at left lower lobe, and a corresponding falling in of the chest. What is the cause of obstruction to the entry of air to the left lower lobe? For the reasons I gave you just now, as it is only the left lower lobe and not the whole lung that is affected, I do not think it can be syphilitic ulceration. We do not believe that he has got an abscess, or carcinoma of the œsophagus, or dilated left

auricle or primary growth in the bronchus, and so the diagnosis becomes narrowed down to growth in the mediastinum outside the bronchus or to an aneurysm pressing on the bronchus going to the left lower lobe. I saw the man outside the hospital with Dr. G. T. Cooper last spring, and then the signs were as now, and he has certainly not wasted since then, and it seems difficult to believe that if it is a growth, which we know has existed since last spring up to the present time, he should have no secondary growths and not begin to waste. It is very important to remember this clinical point—that by the time a growth in the mediastinum has come to press upon a bronchus it nearly always gives other signs of its presence. I mean this—the fact that we have got no other evidence of its presence is evidence that it is not a case of pressure by a growth on the bronchus. I originally saw the man on account of his profuse bleeding. It was very profuse. There was a large bowl bigger than any ordinary porringer full of bright blood. You will say, "Surely it cannot be an aneurysm with bleeding going on," because he is bleeding again now. The history is that he first bled in the spring very profusely, and then during the summer he bled occasionally, and now in the ward he is bleeding again. I quite admit that such repeated and profuse hæmorrhage as this is very unlike aneurysm. One would have thought that if an aneurysm produced such bleeding it would never stop, and this is strong argument against aneurysm. If it were not for the repeatedly profuse bleeding we should not doubt that the man has an aneurysm. But do not go away with the idea that bleeding from an aneurysm is always immediately fatal. There was a man who died last year who had bled on and off for two years. Such patients may live for even four years, incredible as it seems. The blood oozes through the clot in considerable quantity, and repeatedly passes through some minute hole in the aneurysm, and yet for years this does not rupture fatally.

Diagnoses which do not recognise the importance in this man of pressure on the lower left bronchus are not, I think, so likely as those we have discussed. It has been suggested, as to his hæmoptysis, that he has got phthisis. If he has got phthisis you must allow that it has lasted for at least six months and that at present there are no signs of it except at the left base. You do read in books of basal phthisis. I have never seen a diagnosis of phthisis confined to the base of the lung verified post-mortem. My advice is, avoid the diagnosis, for it is nearly always wrong. It seems to me hard to believe that we should have a man with such extensive physical signs over the left lower lobe lasting so long and yet no physical signs at the upper part of the lungs, if the man is suffering from phthisis.

It has been suggested that he has got chronic pneumonia, especially as he is said to have had pneumonia some years ago. All I can say again is that the diagnosis is never verified post-mortem. We have no specimen in our museum of chronic fibrosis following on acute lobar pneumonia. Although I do not deny the possibility of the correctness of such a diagnosis, yet I feel extremely shy in making it. Even if the man does turn out to have this condition, it is so rare that I very much doubt whether it is good clinical medicine to have made the diagnosis on the evidence we have before us.

I want to tell you about another case to illustrate the importance of grasping the fact that chronicity of pulmonary signs is of value in diagnosing aneurysm. Some years ago, during a heavy take-in, I saw a woman in Mary ward and the house-physician said, "This case is one of chronic bronchitis." I listened and found that she had chronic bronchitis and asked the ward clerk to get a report ready for the next day. But when I came down to the hospital next day I found that she was dead. I turned to the doctor who had sent her up—he had come to the post-mortem—and said, "Your patient is dead; I am rather surprised." He said, before the body was opened, "I am not, she has got an aneurysm. I believe it is an aneurysm, because for a long time I have tried and have not been able to cure the bronchitis." He turned out to be correct. It was a smart diagnosis, especially as the patient was a woman. His reasoning was logical. The

woman had bronchitis, and in spite of everything that could be done it remained. She must therefore have a permanent cause keeping it up. What are the permanent causes of bronchitis? The common ones are growth, tubercle, aneurysm. There was no evidence of growth, no tubercle; therefore the cause is probably an aneurysm. How important, then, it is to grasp the importance of permanency of lung symptoms. In all the four cases to-day the lung symptoms have been permanent.

Before leaving the subject of the lungs I ought to remind you that I have attributed all the effects in the lung to pressure on the bronchus itself, because I have been able to explain them in that way; and it is a good rule, when you have a reasonable explanation, to keep to it until it is shown to be wrong. I ought to mention that some great masters of medicine were inclined to attribute the septic pneumonia, and the general changes in the lung which result in these cases to pressure on the nerves going with the bronchus. They regarded the changes as trophic, and this may be so.

The next great symptom that I want to take in connection with aneurysms is pain. Several of our cases had pain, and I do not know that there is anything that I want you to be more careful about than how you make a diagnosis of pleurodynia or intercostal neuralgia, for such a diagnosis is the cause of perhaps as much slipshod medicine as any diagnosis ever made. I really think, if you do your work carefully and try to get to the bottom of each case, that you will not require to diagnose pleurodynia, or intercostal neuralgia once a year. Very often when such a diagnosis is made, it is a slovenly diagnosis, and is far away from the cause of the pain. Here is the report of a man in 17 bed, Philip. "In March, 1902, patient began to feel a pain between his shoulder blades which caught him whenever he took a deep breath. As he got worse he was attended by a doctor who diagnosed pleurodynia and poulticed him. On June 5th he was admitted into another hospital where he was treated for neuralgic pains and was discharged much better. On July 12th the pain was much worse and a fresh doctor was called in who gave him morphia," That shows you how very severe the pain is. On going over the case we found evidence that the man had an aneurysm. So you will please never forget the pain of aneurysm. Let me take another case. I saw an elderly gentleman two years ago, my notes are :—"He was well till two years ago, and he then had pain all round the chest. A distinguished doctor who saw him abroad said he had indigestion. The pain was mostly in the dorsal region." On examining him I found dulness at the second right intercostal space, suggestive of aortic dilatation but nothing more. I made a note saying the case was probably one of aneurysm. Recently the patient had a fall and died in a few hours, evidently from internal hæmorrhage. At the post-mortem examination it was found that in his fall he had ruptured a large aneurysm which contained a pound of clot. So here was an aneurysm which had given no sign two years before excepting a slight pain in the chest, and the pain had been put down to indigestion, but it was due to aneurysm. You will say, "Does it matter, I cannot cure an aneurysm?" It matters immensely. You think the pain is due to indigestion or pleurodynia, or inter-costal neuralgia, and you say to the man, "You will be all right, there is nothing important the matter with you." The man goes away pleased and drops down dead from a ruptured aneurysm.

Remember that aneurysmal pain is mostly constant and it is often very severe, it may be almost anywhere in the chest and it is peculiarly intractable.

The next point I want to direct your attention to is the brassy cough. That is most suggestive of aneurysm. Why it should be brassy I do not know, but once heard it can never be forgotten. But do not think that it is necessarily a symptom of aneurysm, although certainly most people with a brassy cough have an aneurysm. I can tell you a case in point. Some three or four years ago, when taking Clinical, we had a man with malignant disease in his chest and consequent bronchitis. The cough was so brassy that more than one observer when he walked into the ward, if the patient

happened to cough at the time, remarked, "That patient must have an aneurysm." The autopsy showed that there was no aneurysm, but there was malignant disease. If you go into the museum you may see a specimen of syphilitic stenosis of a bronchus and the patient had a brassy cough. So a brassy cough may occur in other conditions than aneurysm.

Another sign of immense importance in the diagnosis of aneurysm is the condition of the larynx. An aneurysm may press upon the left recurrent laryngeal nerve and lead to paralysis of the left vocal chord. That cannot occur except from organic disease. It must mean either that there is local disease in the larynx, or that there is organic disease implicating the nerve fibres which supply the muscles of the vocal chord in some part of their course. Usually this organic disease is an aneurysm pressing on the recurrent laryngeal nerve. Do you remember a man, a year ago, who was in Philip, and concerning whom it was at first very doubtful what was the matter? He had some pain and he had a murmur. Both might have been due to aortic disease. We looked at his larynx and the left chord was immovable. That clenched the diagnosis in favour of aneurysm. What you should remember about all these signs which I have brought before you this afternoon is, that if they are constant their importance cannot be exaggerated.

There are many other signs of aneurysm which often occur, and which are not nearly so important, for instance, the *pupils*. Some of these patients had unequal pupils. One year in Clinical we got very interested in the subject because we had some cases of aneurysm, and on several occasions we looked at the pupils of most of the patients in the ward, and we learnt that a little inequality in the pupils is by no means uncommon, and further, that such inequality varies from day to day. So that before you lay stress on inequality of pupils as a sign of aneurysm, remember such inequality must be undoubted and constant.

The same is true of the pulse. If you will investigate the matter you will be surprised how often the pulses are not quite equal in persons in whom there is no reason to suspect aneurysm. So that before you attach any importance to a difference in the pulses as diagnostic of aneurysm, be quite certain it is marked and constant. The same is true of tracheal tugging. You may meet with a slight degree of this in health. With regard to murmurs they often do not help in diagnosis, for an aneurysm may exist without a murmur, and further, even if an aneurysm is present, a murmur may be produced in the heart, or it may be hæmic. I have grouped together pulmonary signs, pain, brassy cough and laryngeal paralysis, for in difficult cases I believe we get most help in the diagnosis of aneurysm from these, while on the other hand I think in difficult cases inequality of the pupils and pulses, tracheal tugging, and murmurs may easily lead you astray. One other sign I have noticed students do not understand is œdema. As a rule, almost without exception, marked œdema is in favour of growth rather than aneurysm. The reason is easy to find. A growth produces œdema because it grows into the vein and obstructs it. An aneurysm only obstructs the vein because it presses on it. So that œdema is far more marked in growth than in aneurysm. There are, as you know, many other signs of aneurysm, for example, dysphagia, but we have to-day only discussed those which were present in one or other of our seven cases.

I had hoped to go over the treatment, but there is obviously no time for this, but I trust I have shown you that the diagnosis is a matter of importance. Do not think it is not because unfortunately you cannot cure aneurysm. It is highly important to a man to know whether probably his life is only a matter of months or whether he is suffering from indigestion.

Note.—By an interesting coincidence when we returned to Miriam ward after lecture we found a woman had just been admitted who appeared to be suffering from heart disease, but we noticed that there was deficient entry of air over the upper part of the left lung; thereupon we looked at the larynx and found the left vocal chord completely paralysed, which made the diagnosis of aneurysm certain.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

South African Memorial.

SIR,—A memorial will shortly be erected within the precincts of the hospital to the memory of those Guy's men whose lives were lost in the service of their country during the South African War.

The memorial will take the form of a Drinking Fountain to be placed in the Colonnade; and a suitable design by Mr. Frederick Wheeler, F.R.I.B.A., has been selected.

The committee is very anxious that the names of all Guy's students, past and present, who lost their lives in the war, should be recorded on the memorial. At present the list is as follows:—H. A. Bryant, H. Bernard-Onräet, R. T. Fitz-Hugh, L. J. Hughes, T. Jones, H. Pope-Walker, F. M. Russell, C. B. Sells, F. Welford, S. Whicher.

If there are other names which have not been brought to the notice of the Memorial Committee, I trust this letter may be the means of eliciting the desired information.—I am, your obedient servant,

FREDERICK TAYLOR.
1st Nov., 1902. Senior Physician to Guy's Hospital.

Gazette.

DEAR MR. EDITOR,—I take the liberty as a constant reader and one who receives the GAZETTE by post, of writing to suggest that your excellent paper should contain more *Clinical* matter. For example: in your paper of October 25th, I read in "Passim" that there have been three cases of Cæsarian Section in a period of eight days; if the detailed treatment of these cases were published instead of the bare fact of their existence, how much more interesting it would be to your readers!

A few notes of the most interesting cases in Clinical, also occasional notes from the Out-patients would again be of great value and instructive to the General Practitioner. The old system of publishing long lists of the cases in the hospital was a good thing omitted. A few remarks on Anæsthetics with details of any unusual case might interest many in general practice.—Yours truly,

MONTAGUE WAY.

Kenilworth Lodge, Southsea.

Guy's Hospital Physical Society.

A MEETING of the Physical Society was held in the Library on Wednesday, October 22nd, Mr. Blake-Odgers in the chair.

The evening was devoted largely to the exhibition and discussion of nervous diseases, some interesting cases being shown.

The only surgical case was shown by Mr. Bowen, who brought before the society a patient whose breast had been removed for carcinoma six months previously, the pectorals being also taken away and the axilla cleaned out. Recurrence had taken place in this operation. Scar, and the glands in the opposite axilla shewed enlargement.

Mr. Parker shewed a case of idiopathic muscular atrophy.

Mr. Owen Richards, one of pseudo-hypertrophic atrophy, and

Mr. Pearson a case of disseminated sclerosis.

Mr. Matheson brought forward a case which presented some difficulties in diagnosis, this lying between angina and aneurysm.

The next meeting will be a Pathological evening, on Wednesday, Nov. 19th, Mr. Blake-Odgers in the chair. Members willing to shew cases please communicate with Mr. Blake-Odgers.

Washbourn Memorial Fund.

SECOND LIST OF SUBSCRIPTIONS.

The following subscriptions to the above fund have been either paid or promised:—

	£	s.	d.
Subscriptions previously acknowledged	61	19	0
Mr. Cosmo Bonsor	2	2	0
Dr. Pavy	2	2	0
Dr. Pye-Smith	2	2	0
Dr. George Turner	2	2	0
Mrs. George Turner	2	2	0
Dr. W. G. Rogers	2	2	0
Dr. E. T. Hamilton	2	2	0
Mr. F. Golding-Bird	2	2	0
Mr. W. Washbourn	2	2	0
Mr. L. A. Dunn	2	2	0
Dr. Elcum	2	2	0
Dr. Daldy	1	1	0
Dr. Adeney	1	1	0
Mr. C. Spurrell...	1	1	0
Dr. Handley	1	1	0
Mr. J. R. Bosworth	1	1	0
Dr. C. D. Muspratt	1	1	0
Mr. Montague Hopson	1	1	0
Mr. L. H. McGavin	1	1	0
Mr. Gerald Sichel	1	1	0
Mr. Muriel	1	1	0
Mr. E. J. F. Hardenberg	1	1	0
Mr. F. Durham	1	1	0
Dr. R. O. Moon	1	1	0
Mr. Julius Mann	0	10	6
	£99	4	6

Passim.

In reply to a query we should like to repeat our statement that the address delivered by Sir Samuel Wilks, Bart., F.R.S., to the Hampstead Scientific Society in May last, has been printed by the Society and may be obtained from the Librarian, Mr. Mills, at the extremely modest sum of sixpence, or from Sydney Mayle, 70, High Street, Hampstead.

The Residents' Annual Dance will take place this year on Tuesday, November 25th, in the Court Room, by kind permission of the House Committee, between the hours of 8.30 p.m. and 1 a.m. Mrs. Cosmo Bonsor has kindly consented to act as hostess on behalf of the Residents, and Mrs. Perry has most graciously granted the use of her house. The arrangements will be practically the same as last year, with the innovations then introduced, as it is felt that it is a pity to try to improve on so acknowledged a success. Tickets (gentlemen 10s. 6d., ladies 7s. 6d.) may be obtained through any member of the Dance Committee: Messrs. Pearson, Odgers, Atkins, Brydone, and Gray.

Few, if any, of the loyal thousands that greeted their Majesties in their royal progress were aware how much they owed to the persistence and ability of the Mayor of Southwark, to whose unceasing advocacy of their cause the seat-holders owed the very existence of another procession through South London at least. One interesting feature of the procession was the ingenious way that some nurses played on the policeman's soft heart, and franked with the convincing pass of a St. John's Ambulance, "bluffed" the military and gained a view from the comfortable seclusion of the bridge itself.

The death of William Ellis, formerly a servant of St. Thomas's Hospital, in the Borough, has severed one of the last links that connected St. Thomas's with its ancient Borough home. He may have been in those far off days an interested spectator of the actual fights between the rival hospital dressers for the accident cases which took place in the courtyard across St. Thomas's Street; to this rivalry may be traced, perhaps, the customary "bobbies' beer," given by the "take-in" dresser in return for each accident they brought, a custom that is now extinct.

Rumours of startling innovations on the part of the authorities reach us. It is said that the College Library is not the boon it might be, and that a library and reading-room is required for the residents in the College in the evening, and changes are suggested. It is much to be hoped that some arrangement may be arrived at whereby the literature of the day and of the nation may be more readily available in the only free time of the average resident, the "blindman's holiday" and the winter evenings.

A change has come over the outlook of the recently qualified, the meaning and result of which are as yet hidden from us. In the paths trodden by the footstep of ages men are apparently to remain no longer. For the last seven years no one of the standing of Clinical has entered the R.A.M.C., and now we hear of several of professional attainments of no mean order, who will set out to find a career in the path that had seemed closed but is now actually and undeniably re-opened. We are glad of the changed ideas relative to the R.A.M.C., and we believe that the right type of man will represent the hospital's share in the "lordliest game on earth," and we are equally sure that the choice will never be regretted by them.

Fond as most professional men are, at heart, of notice in their professional capacity, it is rare for a hospital Resident to find his name correctly stated at length in the half-penny paper without its provoking in him some unseemly comment or display. It is presumably not libellous to quote from evidence given in open Coroner's Court, but newspapers are not over careful of how they represent facts, and all men sympathise with the numerous victims of the reporter; neither, we may add, is the object of the publicity of inquests served by blazoning the doctor's name at large in all and every judicial enquiry.

THE meetings of the Physical Society are now held on Wednesdays, and it is to be hoped will be well attended. Last year, owing to some mishap, there was a very small exhibition of specimens, with the result that the meeting would have proved a failure but for the Charity contribution, at short notice, of all the Queen specimens, with some of which he was imperfectly acquainted, but which seemed to be inexhaustible in quantity and astounding in quality, some pathological experts having no conception of the nature of some of the specimens. The prize subject is also pathological, being the obscure subject of "The Pathology of Chorea."

MANY and varied were the letters we received in reply to a note in the last number, and we publish one that fairly expresses the general view. It was impossible to publish all, and some were so flattering that we feared lest our contributors should be unduly elated. It may be, however, freely stated that humorous and inoffensive writing is a gift, and that poetry and parody if not as extinct as the Dodo, are at any rate as rare as the great Auk, but we live in hopes of a recrudescence.

"IT may be said that dangerous and daring *ignorance* in medicine corresponds to plausible and perverted *ability* in law in inflicting great suffering on the unsuspecting and much-enduring public."—*Medical Ethics.*

"WHY, bless my soul," said the wearied H.-S., "why couldn't you stop the epistaxis yourself?"

A.H.S.: "I have plugged the anterior nares and tried all the ordinary remedies *except gelatine*!!!"

[Who, after this, will doubt the greater erudition of the modern student.—ED.]

ERRATUM.—In the notice of Odol, No. 376, Vol. xvi., Sept. 13, 1902, in the sentence "among which it is impossible to recognise the essence mint and fennel," read "possible," the exact opposite of what is there stated being correct.

Three Cæsarian Sections.

AT the present moment there are in Queen ward three patients who have lately successfully undergone this operation. This is a record in the annals of Queen, and a few notes of the cases, which resulted in fine well-developed infants, may be of interest to the readers of the GAZETTE.

I.—Charlotte C., æt. 24. This patient was admitted on October 3rd, two days before the onset of labour, nine months pregnant, and the presentation was left occipito-anterior.

Previous history.—She had one previous confinement in May, 1901. On this occasion she was admitted into Victoria ward after being in labour forty-eight hours, the head being on the perineum eighteen hours. The child was born dead without assistance, the head showing extensive moulding. After labour severe sloughing of the vagina took place, principally on its posterior and lower aspects: there was a considerable purulent discharge with fæcal odour. As a result of this sloughing extensive cicatrisation took place in the vagina.

The external measurements of the pelvis were as follows:—

Between anterior superior spines ...	9 in.
Intercrestal	10½ in.
External conjugate	6¾ in.

On making a vaginal examination, a circular constriction was felt half-way up the vagina, above this is a second circular ring just below the cervix. The posterior part of the vulva is also very rigid owing to cicatrisation. There was no evidence of any fæcal fistula. Labour commenced on the morning of Oct. 5th, and by 2 p.m. pains had become strong. By 8 p.m. the os was dilated to the size of a 4/- piece, and was apparently merged with the two cicatricial bands, the whole forming a rigid ring, like "a metal band" which did not show the least signs of yielding. At 10 p.m. Dr. Galabin operated; the membranes were unruptured, the pains were violent and frequent.

A.C.E. followed by ether was administered.

An incision six inches long was made in the middle line extending two inches above the umbilicus. A flattened out Hodge's pessary was placed on the front of the uterus and an incision made through the uterine wall within it. The incision was then enlarged, and the uterus kept well against the abdominal wall by the fingers of an assistant hooked under each end of the opening. The membranes were ruptured and the right arm seized, and the fœtus extricated head first. The cord was clamped with Spencer Wells forceps and cut. During this operation the second assistant standing to the right of the operator, firmly grasped the broad ligaments on either side of the uterus to control the bleeding. The placenta and membranes were rapidly scraped off, and a sponge soaked with hot perchloride placed within the uterus. The uterine incision was then temporarily clamped with three pairs of large Spencer Wells forceps, when the uterus distinctly

hardened. A hysterectomy was then performed in the usual way, the cut cervix being united with interrupted silk sutures, and the stump covered with peritoneum united by a continuous silk suture. The abdominal cavity was then swabbed out with sponges and the incision closed in the usual way. Artificial respiration was necessary to resuscitate the infant, which was a healthy female weighing six pounds. Patient had an irregular temperature between 99° to 101° for about a week, but made a complete recovery.

II.—Maria D., æt. 27, unipara. Patient has had one previous confinement six years ago, a full-time child being presumably delivered by cephalotripsy; patient stating that it "came away in pieces."

She was admitted to Victoria Ward on October 16th from the District, having been in labour for forty-eight hours. Condition on admission—pulse 110; pains frequent, but not very powerful; abdomen very prominent and pendulous. Head firmly fixed in pelvic brim, but high up, so that the greater part is above the brim. Presentation, R.O.A.; fœtal heart heard on the right side of abdomen; uterus closely contracted upon the child, but not in a tonic condition.

Measurement of pelvis—

Interspinous	9in.
Intercrestal	10in.
External Conjugate	6¾in.
Diagonal Conjugate	3½in.

The patient, therefore, evidently had a small, round pelvis. The pubic arch was narrow. There was a large caput succedaneum.

During a pain, the surface of the abdomen became uneven from the moulding of the uterus to the fœtus. A part near the fundus in front is soft and spongy, suggestive of the placenta. The cervix was soft and dilatable, but hanging like a fringe. The membranes were ruptured.

At 10 p.m. Mr. Targett operated. A.C.E., followed by ether, was administered. A median incision was made about six inches from two inches above the umbilicus downwards. The uterus was pressed forwards by an assistant and incised in the centre of the exposed surface. The incision came down on the placenta at once, and as the margin could not be felt, the whole placenta was rapidly detached and removed. The child was then seized by the first limb which presented. This proved to be the left arm. The left leg was therefore grasped, and the trunk and limbs drawn out. The head, however, was tightly gripped by the uterus below, and the uterine incision had to be elongated before the head could be liberated. The child, which was a healthy female weighing 6lbs., was soon stimulated to breathe and cry. During these proceedings the broad ligaments had been firmly grasped on either side by an assistant to control the hæmorrhage. The emptied uterus was then squeezed out of the abdomen and the membranes peeled off. The edges of the uterine incision were united with numerous deep interrupted silk sutures, penetrating the greater part of the thickness of the uterine wall. Small superficial sutures were used to adapt the peritoneal edges. The uterus was wiped out, though very little clot had escaped into it, and returned into the abdomen, and in order to sterilize the patient, one-third of an inch was cut out of each fallopian tube and the ends ligatured. The abdominal wound was then closed in the normal way. With the exception of some tympanites on the first three days, with a rise of temperature to 100°, which was relieved by turpentine enemata, the patient made an uneventful recovery.

III.—Lizzie H., æt. 34, admitted on October 20th. This patient is also a unipara, having had labour induced at the seventh month, sixteen months previously; the child was born dead. She has infantile paralysis in both legs, and at the time had to go about on crutches; she has been greatly relieved, however, by tenotomy of each Tendo-Achilles.

On admission she was nine months pregnant, the fœtus was presenting by the vertex, the back being in front and directed to the left side. Fœtal heart heard distinctly. The pelvis was of an infantile shape, the chief contraction being transverse; the measurements were as follows:—

Interspinous ,, ...	9 ins.
Intercrestal	9½ ins.
External conjugate	7¼ ins.
Diagonal conjugate	4½ ins.

The pubic arch was narrow, just admitting two fingers.

Labour pains started at 2 p.m. on October 21st, and at 10 p.m. Dr. Galabin decided to operate, the os then admitting two fingers, the membrane being unruptured. The abdomen having been thoroughly cleansed an incision five inches long was made in the middle line, extending two inches above the umbilicus. A flattened out Hodges' pessary was placed on the uterus and an incision made within it, this was afterwards enlarged. The placenta was found to be situated in front. The uterus being fixed against the abdominal wall by the fingers of an assistant hooked under the ends of the incision, the placenta was incised and the child extracted, the left leg being seized. The cord was clamped temporarily with Spencer Wells forceps and cut. Meanwhile the broad ligaments on each side of the uterus were firmly compressed by an assistant standing on the right side of the operator. The placenta and membranes were rapidly cleared out of the uterus, which was brought forwards out of the abdomen. The margins of the uterine incisions were then brought together by numerous interrupted silk sutures extending as far as the mucous membrane. Some hæmorrhage arose at this point owing to the uterus failing to contract properly, the patient being rather deeply anæsthetised. By rubbing and compressing it, however, it soon hardened. The peritoneal surfaces were approximated by interrupted sutures of fine silk.

The patient was sterilised by ligature and removal of about one-third of an inch from each Fallopian tube.

The abdomen was closed in the usual way. The patient made an uninterrupted recovery. The child was quite healthy and did not need artificial respiration, it weighed five and a half pounds.

In conclusion, it may be worthy of note that the patient who made the most speedy recovery was the last, and that in this case the operation was performed at the commencement of labour, before she was in any way exhausted.

In each case the chief reason for performing Cæsarian section was to procure a living child. In the *first case* Cæsarian section was practically imperative, the only other alternative being cephalotripsy, and there would have been great difficulty in performing this operation, owing to the extensive cicatrisation of the vagina. If it might have been possible, it would only have been at the expense of severe laceration of the cervix and vagina. Hysterectomy was performed in this case to ensure sterility, and at the same time by removing the whole uterus to lessen the risks of septic trouble.

In the *second case* Cæsarian section was performed entirely in the interests of the child, as owing to the contraction of the pelvis a living child could not have been born, cephalotripsy being the alternative. In the last case, again, Cæsarian section was performed in the interests of the child. This patient was to have come in at the seventh month for the induction of labour. The chief contraction here was transverse, and more especially at the pelvic outlet, and in all probability a cephalotripsy would have had to be performed in this case as well.

H. C. K.

The "Contemporaries" Club.

THE Annual Dinner of the Club, will be held at the Trocadero, on December 13th, at 7.30 p.m.

(Graham Simpson, Esq., F.R.C.S. Eng., in the Chair.)

A Meeting will be held at 7.15 for the purpose of electing a Vice-President. Gentlemen intending to dine are requested to notify one of the Hon. Secs. before Dec. 10th. The cost of the dinner will be as hitherto, viz., One Guinea, inclusive of wine. The club includes :—

1. Men who entered the hospital as full students in the years ending Oct. 31st, 1893 and 1894.

2. Dental students taking their full course in the same years.

3. Members of the Universities who came up in their second or later years, during the years ending Oct. 31st, 1895 and 1896.

The Hon. Secs. will be glad to hear from any members who did not receive notice of the dinner last year.

Hon. Secs.: LAWRIE McGAVIN, F.R.C.S.,
21, Montagu Street, Portman Square, W.
ERNEST B. DOWSETT, L.D.S.,
1, Gloucester Street, Portman Square, W.

Obituary.

DEAR SIR,—I enclose a "paragraph" relating to the death of Dr. James Bankart, which may interest an older generation. I commenced my medical career as a student at the Devon and Exeter Hospital and knew him intimately about 1873. He was considered a bold and brilliant operator but he was very reserved in manner, and I think it was in consequence of the latter that he was not so appreciated as he might have been. It was said of him that after being Demonstrator of Anatomy he unsuccessfully competed with the late Mr. Davies-Colley for an Assistant-Surgeoncy and left in disgust at his failure. He was attended by Dr. Davy, a contemporary of his at Guy's, and was also very friendly with Dr. C. Bell, another contemporary, with whom he shared a passionate devotion to music.—I am, yours faithfully, R. J. BRYDEN.

21, Harmer Street, Gravesend.

"After a somewhat protracted illness, Mr. James Bankart, who during the past thirty-two years practised as a surgeon in Exeter, passed away at his residence in West Southernhay, on October 31st, at the age of 68. Since April last, the deceased had been suffering from an internal complaint for which he was attended by Dr. Davy. Jaundice, however, supervened. Prior to coming to Exeter, the deceased had passed eleven years first as student and subsequently as Anatomy Demonstrator at Guy's Hospital, London, and soon after he settled in Exeter he became surgeon at the West of England Eye Infirmary, and a member of the medical staff of the Royal Devon and Exeter Hospital. About eight years ago he relinquished the post of senior surgeon to the latter institution by the operation of the age limit. He enjoyed a high reputation for treating diseases of the eye, and his services were in great request. His principal recreations were music and fishing, and he was an active member of the local musical societies. Great sympathy will be felt for the widow and family."

Notice.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

NOTICE is hereby given that the next Primary and Final Examinations for the Diploma of FELLOW will commence on Thursday, November 6th, and Friday, November 21st, 1902.

Candidates are required to give not less than fourteen days' notice of their desire to present themselves for either of these Examinations.

Particulars relating to these Examinations may be obtained of the Secretary (Mr. F. G. Hallett), Examination Hall, Victoria Embankment, London, W.C., to whom all applications in reference to Examinations should be addressed.

The required Fees must be paid three days prior to the Examinations.

September 23rd, 1902.

Guy's Hospital Dental Society.

THE first winter meeting of this Society was held on Friday, Oct 17th, Mr. P. S. Campkin occupying the chair. The secretary having read the minutes of the last meeting, the president then gave his address. This was followed by a paper on "Hypoplastic Teeth," read by Mr. A. L. Mason, which was followed with great interest, the following gentlemen taking part in the discussion afterwards:—Messrs. Campkin, A. E. Williams, Hooper, Ross, Wallace, Spiller. The proceedings closed with a vote of thanks to the president.

THE PRESIDENT'S ADDRESS.

GENTLEMEN,—My first duty is to express my appreciation of the great honour you have conferred upon me, by electing me as your president for the ensuing year. It was with considerable diffidence that I accepted the position, feeling that it should be entrusted to more able hands. However, it will be my most earnest endeavour to fulfil the duties devolving upon me to the utmost of my ability, and I trust the coming session may prove as successful as any of its predecessors.

I notice a number of new members among us—this necessarily means new students—and in welcoming them to our meetings, I might perhaps quote that oft repeated phrase of THE GAZETTE's Students' number, and congratulate them on their choice of a hospital. I would congratulate them not only because that hospital is Guy's, but by becoming Guy's students, they have the privilege of also becoming members of Guy's Dental Society. Our society is not old in point of years—it was founded in 1894—but by the enthusiasm of our past and present students, with an ever increasing membership, it holds a position unique in hospital life. It has a most distinct educational advantage, the standard of the papers being of high character, exhibiting on the part of the contributors great care and research. The casual communications, too, are invariably of much interest and value, selected from the practice of so large a hospital.

Now, if I might suggest a word of advice to those present commencing hospital life, I would say from the beginning, be thorough. The successful practice of dental surgery demands as one of its first essentials the most complete attention to detail—a dentist must cultivate the capacity for taking infinite pains. Once a habit of exactitude and precision be acquired, it is comparatively easy to so continue; but the least retrogression in this respect creates a necessity for a corresponding effort to regain the same standard. I believe nothing so influences one's future work as the first two years' hospital training. And he who adopts the profession of dentistry, must do so without special regard to financial remuneration. Certainly, the labourer is worthy of his hire, but honest work, honestly performed, should be one's ambition, which brings its own reward.

This spirit of true altruism, is the sentiment Ruskin suggests when he wrote that the respect paid to the physician is founded ultimately upon his self sacrifice.

As a dental society we are keenly interested in the dental problems of the day. These are so many and varied that I propose this afternoon to simply touch upon one or two which have already evoked considerable discussion. Firstly, dental reform as regards illegal practice. We are constantly hearing of the inefficiency of the Dental Act in dealing with the prevalence of illegal practice and company trading, but we must remember that less than a quarter of a century ago dentists had no recognised standing, and it was in the face of considerable opposition that the Act of 1878 was secured. There is no doubt that the absolute prohibition of unqualified practice for gain is the only right and reasonable end to work for, but how to obtain it? The United Kingdom is one of the very few civilized countries in which the unqualified practice of medicine for gain is not prohibited. Mr. Charles Tomes, in a recent letter to the Journal of the British Dental Association, drew attention to this, and pointed out that if this condition exists in medicine, concerned as it is daily with the issues of life and death, how much more difficult will it be to ensure the prohibition of unqualified dental practice. Only recently the clauses relative to the further protection of medicine and dentistry in the company's bill were rejected in Parliament. It remains with us to educate the public and through them approach these apparently apathetic legislators. It must be our duty to enlighten them upon the importance of this subject, our first consideration being not ourselves and our protection but themselves and their protection. And this we might do practically by establishing dental centres for the treatment of the teeth of the poor. A successful scheme would demonstrate most effectually to the public the great advantages to be derived from skilful dental attention, and cause them to appreciate the fact that it is to their advantage that illegal practice should be suppressed. A very reasonable suggestion has been made, and that is for the younger practitioners in our large towns to amalgamate, and form properly equipped dental departments in connection with the various medical dispensaries, where suitable cases, among the members, could be treated for very small fees, cases which would otherwise probably fall into the hands of the unscrupulous and unqualified. By so doing it seems feasible that illegal practice would become unworkable with a thus enlightened public. For our necessitous poor in London, and a few large cities, there are dental hospitals, but the material to work upon is far in excess of their capacity.

In many provincial towns matters are far worse. There is, perhaps, a dental surgeon attached to the local hospital or infirmary, attending one or two hours each week, but where very often no operation other than extraction is performed. If the dentists holding these posts could see their way towards more conservative practice, nothing but good could result both to the patients and the public appreciation of dentistry.

The country is certainly recognising more and more the value of efficient dental treatment and the opinion

of the dentist as an expert. This is evidenced by the government appointment of a dentist on the Royal Commission to report on phosphorous poisoning in the match-making industry; and as a direct result of that enquiry the principal match factories all have now a qualified dental officer in attendance on their employees; and again, the dispatch of dental surgeons to work in conjunction with the Royal Army Medical Corps on active service. Still more satisfactory would be the permanent appointment of dental officers for the systematic examination and treatment of the men both of our army and navy. It is absurd to insist upon a certain standard of excellence as regards the condition of the teeth of recruits, and to make no attempt to maintain that condition when once the men have enlisted.

Our government, too, might undertake to form a Board of Dentistry, that Board to attach dentists to all schools and offices under its control. By so doing, in course of time, healthy mouths among the people generally would be the rule and not the exception. The effect of this would be far-reaching, for healthy mouths mean healthy people, and a healthy people would mean increased energy and prosperity to the country, the working capacity of the nation increasing with the improved health.

The last point I shall touch upon is our future dental education. The present system of pupilage does not seem entirely satisfactory. The suggested alternative of hospital mechanical training is not without many objections. A judicious combination of private pupilage with a period of special mechanical training in a hospital or technical school seems likely to yield the best results.

As regards the ultimate qualification, the only dental diploma recognised for practice in this country is the L.D.S. of the College of Surgeons of either England, Scotland or Ireland. It is being increasingly felt in many quarters that something further is necessary in the shape of a higher diploma. A surgeon takes the M.R.C.S. and can then proceed to the F.R.C.S., a physician from the L.R.C.P. to the F.R.C.P., but the dentist, with the one exception of the Birmingham University, which recently has instituted degrees of Bachelor and Master of Dental Surgery, should he wish for a higher qualification, has to seek one in another field, usually that of medicine. Certainly, to the man with time at his disposal it is an additional qualification, but it has been much debated as to whether it is higher, in the true sense of the word, to the dentist.

You may have heard that the University of London has been considering the advisability of granting dental degrees. The leaders of our profession have discussed this subject, some advocating the idea that the candidate should take the M.B. London, before presenting himself for the proposed dental degree. An alternative was, I understand suggested, that the candidate should take the first M.B. (Anatomy and Physiology), and then at this stage branch off to a course of study especially relative to dentistry. This proposal seems to me more likely than the former, to produce men better qualified for future dental practice.

It is again a question upon which there is much divergence of opinion, and is still, I believe, sub judice.

Gentlemen, I will not detain you longer, but thank you for your attention to these few remarks. In conclusion, I would remind you that our society has attained its present position by the work of those in the past, and if its future is to be progressive it must be by the continued efforts of its present members.

University of Cambridge

EXAMINATIONS FOR MEDICAL AND SURGICAL DEGREES.

MICHAELMAS TERM, 1902.

PLAN OF EXAMINATION.

SECOND EXAMINATION.

(HUMAN ANATOMY AND PHYSIOLOGY.)

Monday, December 8th, 9 a.m. to 12 m.—Human Anatomy I. 1 to 4 p.m.—Human Anatomy II. Tuesday, December 9th, 9 a.m. to 12 m.—Physiology I. 1 to 4 p.m.—Physiology II. (In the Physiological Laboratory and Small Room of Guildhall).

Saturday, December 13th, 9 a.m.—Section A. Practical and Oral Examination in Physiology (in the Physiological Laboratory).

Monday, December 15th, 9 a.m.—Section A. Practical and Oral Examination in Anatomy (in the Anatomical School). 9 a.m.—Section B. Practical and Oral Examination in Physiology (in the Physiological Laboratory).

Tuesday, December 16th, 9 a.m.—Section B. Practical and Oral Examination in Anatomy (in the Anatomical School).

THIRD EXAMINATION.

PART I. (PHARMACOLOGY AND GENERAL PATHOLOGY.)

Monday, December 8th, 9 a.m. to 12 m.—Pharmacology. 2 to 5 p.m.—General Pathology.

Thursday, December 11th, 2 to 5 p.m.—Pharmaceutical Chemistry (Oral and Practical). (In the Chemical Laboratory.)

Friday, December 12th, 9 a.m.—Practical and Oral Examinations in Pharmacology and in General Pathology. Saturday, December 13th, 9 a.m.—Practical and Oral Examinations in Pharmacology and in General Pathology. (In the Pathological Laboratory.)

PART II. (MEDICINE, SURGERY, AND MIDWIFERY.)

Tuesday, December 9th, 9 a.m. to 12 m.—Principles and Practice of Surgery. 2 to 5 p.m.—Principles and Practice of Physic I. Wednesday, December 10th, 9 a.m. to 12 m.—Midwifery. 2 to 5 p.m.—Principles and Practice of Physic II. (including Special Pathology and Elements of Hygiene). Thursday, December 11th, 9 a.m. to 12 m.—Principles and Practice of Physics III. (including Medical Jurisprudence). (In the Senate House.)

Thursday, December 11th, 2 p.m., and Friday, December 12th, 9 a.m. and 2 p.m.—Oral Examinations in Surgery (in the Masonic Hall).

Saturday, December 13th, 9 a.m. and 2 p.m., and Monday, December 15th, 9 a.m.—Oral Examinations in Surgery and Midwifery (in the Masonic Hall). Clinical Surgery (at the Hospital).

Tuesday, December 16th, 10 a.m.—Clinical Examination in Medicine (at the Hospital). 2.30 p.m.—Morbid Anatomy, Microscopical Specimens, and Oral Examination (in the Pathological Laboratory).

Wednesday, December 17th, 10 a.m.—Clinical Examination in Medicine (at the Hospital). 2.30 p.m.—Morbid Anatomy, Therapeutics and Prescriptions, and Oral Examination (in the Pathological Laboratory).

Thursday, December 18th, 10 a.m.—Clinical Examination in Medicine (at the Hospital).

EXAMINATION FOR DEGREE OF M.C.

Thursday, December 11th, 9 a.m. to 12 m.—Pathology, and Principles and Practice of Surgery. 2 to 4 p.m.—Essay on Surgical case and Topic relating to Surgery.

Friday, December 12th, 9 a.m.—Oral Examination and Surgical Operations. Surgical Anatomy and Clinical and Oral Examinations (at the Hospital)—to end on or before Monday, December 15th.

The names of candidates for these Examinations must be sent to the Registrary on or before Monday, November 24th. Candidates who are members of the Senate may send their names to the Registrary direct. All other names must be sent through the Prælectors of the respective Colleges.

The certificates of candidates, accompanied by their postal addresses, must be sent to the Registrary on or before Wednesday, December 3rd.

The fees for each Examination must be paid to the Registrary when the certificates are sent in. *The fee is £3 3s. for each Part of the Third Examination;* but for candidates who passed both parts of the Second Examination before 1st January, 1900, it is £2 2s.

Registry, 22nd October, 1902.

IMPORTANT NOTICE TO MEDICAL STUDENTS.

At the CONGREGATION on *Thursday*, 6 November 1902, the following Grace will be offered to the Senate:

That, on the recommendation of the Special Board for Medicine, the following Temporary Regulation for Medical Degrees be added to those approved by the Senate on 23 May 1901, namely,

"6 a. That any student who has before 1 October 1902 passed both parts of the Second Examination be allowed before admission to the sections numbered (1) and (2) of the Second Part of the Third Examination under the new Regulations, to produce the Certificates of attendance on lectures, etc. required for the First Part of the Third Examination under the old Regulations."

Guy's Hospital Students' Club.

THE October General Meeting of the Students' Club was held in the Physiological Theatre on Thursday, October 30th, at 4.15 p.m., Dr. Pye-Smith was in the chair.

Present: The Treasurer, Hon. Secretary, and about thirty members.

The minutes of the previous meeting were read and confirmed.

The Treasurer then presented the balance-sheet, and explained that by means of the most rigid economy the Club had a balance of £14 17s. 4d., but that nothing had been spent on the "up keep" of the Club furniture owing to the inadequate grant from the Clubs' Union. After an exhaustive and lucid explanation of the financial condition of the Club, the meeting accepted the balance-sheet unanimously.

Dr. HALE WHITE then explained the Budget for the year 1902–1903, and made the following statement about the electric light. The contract was given to Messrs. Donnison, Berlyn, Lillem & Co., of Great Portland Street. The total amount of the contract, after some slight alteration had been made, was £182 15s. 1d. The cost of the Gymnasium alone was £37 3s. 2d., leaving the cost for lighting the club rooms at £145 11s. 11d. Dr. Pavy generously paid for the Gymnasium. The College committee promised £50, provided the rest of the money was obtained and the Club allowed them to hold security on the fittings to the amount of £50. The remaining sum of £95 11s. 11d. was promised by Dr. Goodhart.

The thanks of the Club are due to Mr. Kirkland, the consulting engineer, who spared neither time nor trouble in assisting the committee with the practical details of the scheme. The work is now complete.

After the Treasurer's statement, a vote of thanks was passed to Dr. Pye-Smith, and the meeting terminated.

Papers by Guy's Men.

The Position of the Volunteer Regimental Medical Officer. By Surgeon-Captain A. E. Larking, M.D.—*British Medical Journal*, 4th October.

Consumption in the Navy. By Surgeon Gerald Sichel, F.R.C.S., R.N.—*Ibid.*

With Dr. E. W. Ainley Walker, at Guy's Hospital.—*The Clinical Journal*, 8th and 15th October, and 5th November.

On the Modern Indications for Cæsarian Section. By A. L. Galabin, M.D.—*British Medical Journal*, 11th October.

Note on a Double Oöphorectomy in Mammary Carcinoma. By Lawrie McGavin, F.R.C.S. Eng.—*Lancet*, 18th October.

A Note on Scarlet Fever arising after Operations on the Throat. By the late J. W. Washbourn, C.M.G., M.D., F.R.C.P.—*The Clinical Journal*, 15th October.

Reviews.

The price of books submitted for review should in every case be stated.

A Manual of Medicine. Allchin. (Macmillan & Co.) Price 7s. 6d. net.

The fourth volume of the series has now been issued and maintains the standard of its predecessors. There are two interesting chapters included in it which are not usually found in medicine books or medicine, viz., those on Œdema and the Physiology of Blood Pressure. The other chapters are pleasantly if somewhat drily written, and while they cannot be said to show a distinct stage of progress, still they are well up to date in most respects, though "Fatty Degeneration of the Heart" and Influenzal Pneumonia are somewhat scantily dismissed. The book is of a convenient size, well got up, and thoroughly to be recommended for its store of useful facts.

Bacteriology. Catechism series. (Messrs. E. & S. Livingstone.) Price 1s.

Is part of a fairly well-known series of similar works. It is not a method of acquiring knowledge that appeals to many, but this is a very good example of its kind.

Medical Monograph Series: Anæsthetics. (Bloomfield). Price 2s. 6d. net.

We have read the above carefully and find it to be thoroughly sound and reliable. We recommend a careful study of it by all who are starting anæsthetics, and we can only say that we should have liked a little more about the signs of an overdose and a discussion of the actual causes of fatal results. Some of the most pregnant sentences are so little emphasized that it needs to be read with care.

The Practitioners' Guide. By J. Walter Carr, M.D., F.R.C.P., T. Pickering Pick, F.R.C.S., Alban H. G. Doran, F.R.C.S., and Andrew Duncan, M.D., F.R.C.S., M.R.C.P. (Longmans, Green & Co.) Price, 21s.

This work is, as its name implies, essentially a Guide for General Practitioners. It is to them what the Poison Section of the Guy's Pharmacopœia is to ourselves; that is to say, it serves as a reference book in cases of emergency. The simile fails, however, in the fuller details given of each subject and in the wide scope of the matter with which it deals; indeed, so far as many of its subjects are concerned, it is as full as many text-books, and especially is this so in dealing with diseases of incubation and respiration, and with gynæcology.

As a dictionary of medicine, surgery and gynæcology, it is sound and should be useful; a means of education it is never intended to be and obviously would fail if it were.

For those who are travelling abroad with but little room for books it provides fairly inclusive instruction with regard to tropical diseases.

Midwifery is left completely alone. It is in fact what its authors describe it—a handy-book, and as such is excellent.

Text Book of Anatomy. By D. J. Cunningham, F.R.S.

Professor Cunningham has hitherto been known to the undergraduate by his Dissecting Manual, the indispensable assistant to Gray's Anatomy for all who enter examination halls. Now he has brought out not an assistant, but a rival to the old established *vade mecum* of students. His new Text Book of Anatomy is the conjoint work of ten contributors, professors of anatomy at all the chief universities, amongst whom he himself writes on the Brain and Spinal Cord, the Respiratory System, and the Ductless Glands. Distinguished as the authors are, and despite the care and accuracy which have been lavished upon the work, it is difficult to believe that it will to any extent oust the older works. Anatomy, save from its microscopical aspect, is a subject in which there cannot be much advance, except perhaps in better arrangement of the matter, or in occasional small details which would find a place in fresh editions of Quain or Grey. In some points the work is an improvement, and of these the chief perhaps lies in the illustrations, which are of value in that they are all original, whilst surface marking receives an attention which should much assist students in a direction which has perhaps been somewhat neglected hitherto.

Examining Board in England

BY THE

ROYAL COLLEGE OF PHYSICIANS OF LONDON

AND THE

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

The following are the dates on which the Examinations will commence in the year 1903:—

FIRST EXAMINATION.

*Chemistry and Biology.—Tuesdays, January 6th, March 31st, July 28th, October 6th.

Practical Pharmacy.—Wednesdays, January 7th, April 1st, July 29th, October 7th.

SECOND EXAMINATION.

Physiology.—Thursdays, January 8th, April 2nd, July 2nd, October 8th.

Anatomy.—Fridays, January 9th, April 3rd, July 3rd, October 9th.

THIRD OR FINAL EXAMINATION.

†Medicine (1st Paper).—Tuesdays, January 13th, April 14th, July 7th, October 13th.

Medicine (2nd Paper).—Wednesdays, January 14th, April 15th, July 8th, October 14th.

MIDWIFERY.—Thursdays, January 15th, April 16th, July 9th, October 15th.

SURGERY.—Fridays, January 16th, April 17th, July 10th, October 16th.

* The Examination in Practical Chemistry will be held on Fridays, January 9th, April 3rd, July 31st, October 9th.

† Candidates who registered as Medical Students before the 1st January, 1892, are not required to sit for the First Paper in Medicine.

The First Examination (Part I. Chemistry, and Part III. Elementary Biology) will be held in Manchester as well as in London. Candidates should state when sending in their applications whether they desire to be examined in Manchester or in London.

Candidates intending to present themselves for Examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, Victoria Embankment, London, W.C., *fourteen clear days before the day on which the Examination commences*, transmitting at the same time the required Certificates.

All Candidates are required to produce Certificates of Age when entering for the first time for any part of the Final Examination.

All Fees must be paid not less than three days prior to the day on which the Examination commences.

Synopses indicating the range of Subjects in the Examinations in Chemistry, including Chemical Physics, Practical Pharmacy, Elementary Biology, Physiology, Forensic Medicine, and Public Health may be obtained together with the Regulations.

NOTICE TO UNIVERSITY CANDIDATES.

Candidates are reminded that they should send with the Schedule of Certificates when applying for admission to the Final Examination, a certificate from the Registrar or other official of the University showing that they have passed Examinations in the subjects of the earlier Examinations of the Board.

N.B.—Books of Questions set at the several Examinations of the Board for each year from 1887 to 1902 may be had on application to Messrs. Taylor and Francis, Printers, Red Lion Court, Fleet Street, London, E.C. Price 6d. each, post free 6½d.

FREDERIC G. HALLETT,
Secretary.

Pass List.

University of Cambridge, October, 1902.

EXAMINATION IN SANITARY SCIENCE FOR DEGREE OF D.P.H.

(Examined and approved.)

E. C. Hare, F. B. W. Phillips, J. B. Slattery.

Sport.

Rugby Football.

GUY'S 2ND XV. v. CROYDON "A."

Played at Croydon, on Saturday, November 1st, before a moderate crowd.

The kick-off was delayed, as several men had great difficulty in finding the ground. Guy's started well; the forwards carried the ball at once into Croydon territory, and looked like scoring on one occasion. The effort was spoiled, however, as a Croydon three-quarter obtained possession and kicked down the field. The game then became very fast, and was carried on round the half-way line till Wall made a fine opening, and passing to Helyar, the latter had no difficulty in scoring, Bridger adding the two points. Croydon made desperate efforts to equalize, but at half-time Guy's still held the lead.

In the second half, Guy's showed improved form, the tackling being keener, Wall and Earl being conspicuous. Shortly after the interval, Burney cleverly intercepted a pass and got away, being, however, stopped by the back. He repeated this performance almost directly after, and scored far out. The kick at goal failed. Nothing further was scored before time, Guy's winning by 1 goal 1 try to nil. Team:—

GUY'S.—Bridger (back); Earl, Renford, Burney, Helyar (three-quarters); Cutler, Stevenson (half-backs); Watts, Layton, Beaumont, Wall, Clarke, Hogarth, Kidd, Ball (forwards).

REMARKS.—Earl at three-quarters was a distinct acquisition, his tackling being good. Helyar, too, has improved considerably since the beginning of the season. Of the halves and forwards little can be said, the latter must learn to break up sharper, and would do well to imitate Wall in their tackling.

GUY'S 3RD XV. v. KENSINGTON 3RD XV.

This match was played at Wood Lane, on October 25th. At half-time Guy's led by 1 try, scored by Gibson. Afterwards tries were scored by Gibson (3), Husbands (1), Saunders (1); Guy's winning by 1 goal and 4 tries to nil. Team:—

GUY'S.—Husbands (back): Gibson, Reader, Watson, Wight (three-quarters); C. P. Harvey, S. R. Harvey (half-backs); Saunders, Metcalfe, Ball, Dowdney, Stevenson, Myer, Davies-Colley, D. Reynolds (forwards).

GUY'S 3RD XV. v. KENSINGTON 3RD XV.

This match was played at Honor Oak Park, on Saturday, November 1st, resulting in a drawn game, there being no score on either side. Team:—

GUY'S.—Husbands (back); Wight, G. Wacher, Watson, L. Reynolds (three-quarters); Kynaston, Edsall (half-backs); Metcalfe, Dowdney, Davies-Colley, Smart, D. Reynolds, M. R. Smith, Myer, Roberts (forwards).

REMARKS.—The forwards are encouraging, Kynaston played a fair individual game, and Husbands was quite good; but there was but little good kicking or dribbling.

Association Football.

GUY'S v. SURBITON HILL.

This match was played at Honor Oak Park on Saturday, November 1st, and resulted in a win for the Hospital by 5 goals to 1. Guy's lost the toss and kicked off against a fairly strong wind. About ten minutes after the start we forced a corner, which was beautifully placed by Litchfield, Fothergill heading into the net. On the re-start our opponents carried the ball into our half and tried hard to get level. Eventually they forced a corner, from which they equalized. This was the score at half-time.

On changing ends, Guy's immediately showed their superiority, and Barber, who was playing a grand game, added 3 goals, the last being the result of a fine individual run from half-way. Towards the end of the game Norton put in a fine run, and scored with a beautiful shot.

The forwards played very well together, but Berry was inclined to get too close to his outside man before passing. Leeming was very safe at back, but Jones was inclined to be a little uncertain. It would be a very good thing for the men to get into better condition. Team:—

GUY'S.—A. E. Collins (goal); A. Leeming, A. G. Jones (backs); H. E. Perkins, A. F. Denning, P. Pedrick (half-backs); P. C. Litchfield, A. W. Berry, H. Barber, E. L. Norton, G. F. Fothergill (forwards).

INTER-HOSPITAL ASSOCIATION FOOTBALL CUP.

London	bye			
Charing Cross	bye			
St. Bart.'s	bye			
Middlesex	—			
St. George's				
University	—			
Westminster				
St. Thomas's	bye			
St. Mary's	bye			
Guy's	bye			

1st Round to be played off by February 1st.
2nd " " February 16th.
Semi-Final " " March 1st.
Final " " March 11th.

United Hospitals Hare and Hounds.

A five mile handicap was held on Wednesday, October 29th, when Messrs. Crafter of the Blackheath Harriers, and S. W. Fowler-Dixon of the Thames H. & H. laid the trail. Dr. H. A. Munro, U.H.H. & H. and Blackheath, and Mr. H. W. G. Haslegrave, Hon. Sec. of the Blackheath Harriers, judged, and Mr. J. E. Fowler-Dixon, Thames H. & H. and Blackheath started the race and took the times. The result was as follows:—

		START M	START S	NET TIME M	NET TIME S
1 G. A. Simmons	St. Thomas's	1	45	36	46
2 O. S. Norton	Guy's	1	55	37	8⅕
3 P. Gorse	Bart's.	1	0	36	59
4 G. W. Lloyd	Bart's.	2	30	38	30⅘
5 W. H. Orton	Bart's.	2	5	38	37
6 T. E. A. Carr	Guy's	1	55	38	37⅕
7 W. H. Bassett	Bart's.	1	55	40	22⅕
3 F. S. Lister	Bart's., Scr., did not finish.				

Appointments.

CIVIL.

CLARK, J. KENNETH, L.D.S. Eng., has been appointed Dental Surgeon to His Majesty's troops at Aldershot.

JONES, R. ORFORD, L.R.C.P., L.R.C.S. Edin., has been appointed District Medical Officer to the Kingsbridge Union.

LITTLEWOOD, J. O., L.R.C.P. Lond., M.R.C.S., D.P.H., has been appointed Certifying Factory Surgeon for the Mansfield District of the County of Nottingham.

PANTING, LAURENCE C., M.A., M.D., B.Ch. Oxon., has been appointed Honorary Medical Officer to the Royal Cornwall Infirmary, Truro.

TASKER, B. G., L.D.S. Eng., has been appointed Dental Surgeon to the Convent of the Sacred Heart, Hove, Brighton.

NAVAL.

Surgeon F. C. STEARN, R.N., has been appointed to the *Duke of Wellington* for Portsmouth Dockyard.

The following gentlemen have been appointed Lieutenants, Indian Medical Service, J. H. HORTON, F. W. SIME, L. HIRSCH.

Birth.

BERRY.—On October 27th, at Wansford House, Watford, the wife of F. Haycraft Berry, M.D., of a son.

STURGES-JONES.—On October 4th, at Talara, Payta, Peru, South America, the wife of W. E. Sturges-Jones, M.R.C.S., L.R.C.P., L.S.A., of a daughter (Wilfreda Ethel).

Marriages.

BIRDWOOD—DAVIS.—On 9th October, 1902, at St. Mark's Church, Almora, India, by the Rev. H. T. Percy Smith, Chaplain, Gordon Travers Birdwood, M.A., M D., Captain, Indian Medical Service, son of H. M. Birdwood, C.S.I., LL.D., Bombay Civil Service (retired), to Dora, elder daughter of J. S. C. Davis, Indian Civil Service.

CANN—LANGDALE.—On October 23rd, at the Parish Church, Uckfield, Thomas Ponsford Cann, M.D. Durh., of Newhaven, to Ellen Myra, elder daughter of Henry Marmaduke Langdale, surgeon, Uckfield.

ED.—J. M. B.

Contents.

	PAGE
Glandular Tumours in the Neck: Clinical lecture by Mr. Lucas	469–476
In the Medical Wards	476–477
A Misleading Description	477–478
Washbourn Memorial Fund: 3rd List	478
Notices	478
Passim	479–480
Correspondence: The Medical Profession: Guy's Chapel Services	480–481
Somewhat Lighter	481
Guy's Hospital Physical Society	482
Guy's Hospital Debating Society	482–483
Papers by Guy's Men	483
University of Oxford	484
Obituary: Maurice Dunbar Wood	484
Wealth	485–486
South African Memorial Fund: 16th Subscription List	486
Nursing News	486
Sport: Rugby Football—Guy's 1st XV. v. Bedford; Guy's Hospital A v. Beckenham. Association Football—Guy's v. Kenley. United Hospitals Hare and Hounds	487–488

Calendar of Coming Events.

Nov., 1902.

Sat. 22.—Messrs. Golding-Bird and Dunn's take-in; Drs., G. Nunn and M. J. Mottram; Cl., F. H. Parker.
1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Old Merchant Taylors, home.
III., Wasps III., away.
G.H.A.F.C., II., Reigate Priory II., away.

Mon. 24.—1.15 p.m., Clinical lecture by Mr. Targett.

Wed. 26.—G.H.R.F.C., II., St. Thomas's II., away.
G.H.A.F.C., I., Hastings, away.
II., Leavesden Asylum, away.

Thur. 27.—Messrs. Jacobson and Fripp's take-in; Drs., O. V. Payne and G. A. Ticehurst; Cl., O. W. Richards.
G.H.C.U., Address by Rev. T. Currie, M.A.

Sat. 29.—1 p.m., Clinical lecture by Dr. Pitt.
Last day for sending in names for 1st, 2nd and 3rd M.B. Camb. Exams.
G.H.R.F.C., I., The Past, home.
G.H.A.F.C., I., Beckenham, away.
II., Beckenham II., home.

December.

Mon. 1.—1.15 p.m., Clinical lecture by Mr. Higgens.
January Appointment List opens.
Exams. for M.D. and M.S. Lond. begin.

Tues. 2.—Exams. for B.S. Lond. begin.
Last day for sending in Fees and Certificates for 1st, 2nd and 3rd M.B. Camb. Exams.
12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 3.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.P.P.S., Paper by Mr. H. Barber on "Functional Disease."
G.H.A.F.C., I., Godalming, away.
II., Sevenoaks School, away.

Thur. 4.—G.H.C.U., Address by W. Hind Smith, Esq.

Sat. 6.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Northampton, away.
II., Boro' Road College, home.
III., Ealing "A," away.
G.H.A.F.C., I., Cheshunt, away.
II., Cheshunt II., home.

Guy's Hospital Gazette.

NOVEMBER 22, 1902.

Glandular Tumours in the Neck.

CLINICAL LECTURE BY MR. LUCAS.

October 14th, 1902.

GENTLEMEN,—I have brought two cases here to-day illustrating Glandular Tumours in the Neck. One of these is a case of extensive TUBERCULAR INFECTION of the glands on one side of the neck in a young married woman, twenty-three years of age, and the other is a case of LYMPHOSARCOMA in a man aged fifty-seven. He had a rapidly-growing tumour on the side of his neck for which he was in the hospital and operated upon about two months ago.

I will take the case of the TUBERCULAR GLANDS first. This is an affection which is exceedingly common, and one which you will get very familiar with in attending among the out-patients and in the wards of this hospital. The woman was twenty-three years of age and married, living in a low district in the neighbourhood of Bermondsey. She has a remarkably sound family history. We have no reason to suppose from her family history that she would be liable to be infected with tubercle. The report says she is married and has no children. Her father and mother were both healthy and she does not know of any consumption or tubercular disease in her family. She herself has never been ill in her life and has had no trouble in bones or joints or previously in her neck, to indicate a tubercular condition. We must suppose, therefore, that this woman coming of a healthy stock and living in a low neighbourhood in London became reduced in health, was exposed in some way or other to tubercular infection, and that the bacillus penetrated some part, either the tonsil or some part of her

mouth or upper part of her head and passed on to the glands in her neck.

The following is the history so far as her illness is concerned: "She first noticed a small swelling on the right side of her neck at the posterior border of the sterno-mastoid muscle two years ago. It has gradually increased since then, and more swellings have appeared further down, and at the present time she has these swellings extending down the posterior triangle of her neck as far as the clavicle." You see what a chronic history we have here: two years' history of a gradually increasing swelling on one side of her neck. "On inspection two oval swellings can be recognised at the posterior border of the sterno-mastoid each being one and a half inches in diameter, the upper one two inches below the angle of the jaw. On palpation several smaller ones can be felt below the angle of the jaw anterior to the sterno-mastoid. Two more can be felt in the subclavian region just above the clavicle, the lower two large ones can be felt to be composed of two or three smaller portions. They are very hard and freely movable beneath the skin and on the deeper structures. No fluctuation can be obtained. They appear to be situated immediately beneath the skin and are tender. When she swallows they cause her pain."

There you have pretty much the whole history of the case as it was related to me when the patient was in the ward—two years' history of swelling on one side of the neck gradually increasing without any very definite pain, insidiously growing larger, causing just a little discomfort in swallowing now, on account of the size of the swelling, but showing no signs of redness or inflammation. The glands can be felt to be perfectly movable underneath the skin. They are not adherent either to the deep or superficial parts, and they show no signs of softening or suppuration.

A chronic enlargement of the glands on one side of the neck.—What is it likely to be composed of? It is a chronic enlargement of the glands, obviously, because of their rounded outline and their position. You might have a simple *lymphoma* of the neck without any tubercular infection possibly, a condition of which we know very little, in which you find glands enlarged by an increase of normal tissue, with an excess of lymphoid cells, and if you remove them you are unable to say that they have been invaded by any organism with which you are familiar. Another more serious condition is that known as *lymphadenoma*, or Hodgkin's disease, which might begin in a way such as this, on one side of the neck, and gradually spread to the glands throughout the body. This general enlargement of the glands of the body, known as general lymphadenoma or Hodgkin's disease, is commonly associated with an enlargement of the spleen, with deposits in its interior, and frequently also, but not constantly, with a leukæmic condition of the blood. This case going on for two years, and still localised to one side of the neck, could hardly be classed under a condition such as that I have just been speaking of—lymphadenoma; nor as a simple lymphoma. This is a typical case, then, of chronic enlargement of one side of the neck due to tubercular infection of the glands. Why is it that we find the glands of the neck so much more frequently infected with tubercle than the glands of any other part of the body, save perhaps those of the mesentery, which are not to be observed with the eye, and those of the mediastinum, which also are invisible to the eye? So far as tubercular gland enlargement is concerned, you can study it more frequently and better in the neck than in any other part of the body. You may get tubercular infection of the glands of the groin, spreading from some infection about the foot or associated with tubercular fistula. You may get tubercular enlargement of the glands of the axilla from some tubercular inoculation in the course of the upper extremity. But the majority of the cases of tubercular gland disease which you see are found to be on one or the other side of the neck. Sir Frederick Treves has given an explanation of this, inasmuch as he says that those gland collections which are principally affected with tubercle are those which drain a mucous surface in which there is an unusual amount of adenoid tissue; and tubercular affection of those others, the mesenteric glands draining the intestine, and the glands of the mediastinum

draining the œsophagus, pleura and lungs, may possibly be explained under that hypothesis. But I would lead you to a much wider view of the causes of this affection of the neck. Only consider that these glands of the neck drain all the special organs of sense which are collected together at the upper part of the body, and also take into account the large surface exposed to injury, which includes the face, nasal cavities, mouth, pharynx and larynx, and the special liability which there is to infection through the scalp.

Now we will take these different centres of infection in order. Take, for instance, the teeth and think what a liability there is to infection through the gums. Think of the number of times the gum is injured in the course of normal dentition. At six-and-a-half months the infant begins to have his first trouble with his teeth, and twenty teeth have to force their way through the gums making wounds as they go, through which infective processes may take place. These twenty teeth then have to be removed, decayed, absorbed at the roots and discharged, and therefore there are twenty wounds to occur again as they disappear. Now thirty-two other teeth make their appearance and therefore thirty-two more wounds appear, and in the course of a long period these give constant trouble until they are replaced by the aid of the dentist with a third set. How far these other thirty-two will cause further wounds I will leave the dentists to explain. But I point out to you that there are no less than *one hundred and four* wounds inflicted on your gums, not counting the injuries which may occur from the third set.

Well, then, look at the ears, and note the liability to inflammation about the ears. Think of the frequent cases that come under your notice of mastoid inflammation, inflammation perhaps extending through the pharynx to the tympanum and so to the mastoid cells. These glands of the neck are liable to enlargement through any ulceration about the meatus, or inflammation of the mastoid, or of the internal ear. Then, again, you have another delicate sense organ in the nose which is liable in its interior to lupus infection, perforating ulcer of the septum, to caries, polypi, and such like. Then, again, the eyelids may be the source of infection. Numbers of the children in poor localities are liable to sore edges of their eyelids, and once you get a wounded mucous surface there is a liability of the tubercle bacillus getting in there. The lachrymal apparatus, again, is liable to inflammation. There may occur inflammation of the lachrymal sac or duct and an abscess, and from this infective matter may pass to the glands of the neck and infect them. The tonsils are also exceedingly liable to ulceration in various exanthemata as a result of certain poisons. Scarlet fever, diphtheria, measles and various simple inflammations may lead to ulceration and form wounds through which the tubercle bacillus may penetrate. Injuries to the tongue through smoking, or through the teeth may be the cause of infection of the glands of the neck.

But if you want to know the most common source of tubercular infection of the glands in children amongst the poorer classes, it is the scalp. Crowding the out-patients' departments of children's hospitals are little patients suffering from enlarged cervical glands, and if you examine their scalps you will, in the majority of cases, find the hair alive with pediculi and studded with nits. The mothers tell you they cannot prevent this because they attend Board Schools, where their *caps* are hung together and frequently exchanged in play. The ordinary sequence is as follows:—The lice, in feeding, are continually biting the scalp and inflicting wounds, which become infected by the ordinary bacteria of suppuration, the staphylococci, and the like, forming impetiginous spots, from which infection spreads to the glands. On these open sores the tubercle bacillus, which is being blown about in the air, may settle, and so reach through the lymphatics the glands of the neck. In many of the cases of enlarged glands associated with pediculi in the head, if the child be healthy and born of healthy parents having a good resistance against the tubercle bacillus, all that is necessary is to wash the scalp well with a 5 per cent. carbolic lotion, and rub on some ammoniated mercury ointment. You will thereby kill the pediculi, and the ulcerations will heal and the glands

subside, and the child be as healthy as before. That is an ordinary case, where you are dealing with a healthy child, the subject of pediculi in the head and glandular enlargement subsequent to it. You cure the infected sores and the glands cure themselves, and the child having a strong resistance to the tubercle bacillus, nothing further happens. Quite different is it with a delicate, feeble, pale-faced, under-fed child, living in a big town like London, with its glands enlarged under the circumstances I have described. The enlargement does not subside when you have removed the original cause, viz., the pediculi. Even with the change and rest that you may advise, the glandular enlargement remains, and that means that you are now dealing with a much slower, much more insidious infection than that which originally enlarged those glands. You are no longer dealing with the staphylococcus, or some organism which is easily thrown out, when the health of the child is restored, but you are dealing with one slow, insidious process, an infection by the tubercle bacillus.

Now we come back to the case that I related. You find this woman after suffering for two years from an enlargement on the side of the neck, still without any signs of suppuration, which is not unfrequently associated with tubercular infection. In some cases, very probably, there is a mixed infection, then suppuration will occur much earlier than in this instance, where we are dealing with the tubercle bacillus alone. Where suppuration takes place, the gland is soft and becomes adherent to the skin and bursts, and its pus is discharged. In such a case there often follows a fungating ulcer in the neck, and a lupous infection of the skin may spread from that. In this woman, though no suppuration has taken place, degenerate changes are probably present in the glands looking like yellow deposits on section. Owing to the absence of suppuration it is in a stage which is most hopeful for complete cure.

What now is recommended in these cases, is to excise freely the whole of these infected glands. Waste no time in the use of fomentations, application of iodine, ointments, and that kind of thing, but set to work and excise the whole of the affected glands. That is what we did in this case. When you have little experience in operating, and you think you feel two or three little glands in a patient's neck, you may be inclined to treat the case lightly, and tell the patient's friends you will just get a neighbour to come in and give chloroform, and then excise them. Let me warn you against what you are likely to find. You will always find an immense number more glands than you originally felt from the outside, and than you have any idea of. If you want to do the operation thoroughly, you must be prepared for a good afternoon's work. I will read the description of the operation as written down here. "A vertical incision was made over some of the most prominent glands behind the sterno-mastoid, and they were found to be just under the platysma, and were carefully dissected out. As they were removed more glands came into view, which in their turn were removed. The incision was then carried further down and many more glands, large and small, were found." Those enlarged glands that you see and feel from the outside are only a small number of those to be removed. "They were found underneath the sterno-mastoid and underneath the trapezius, over the carotid arteries and lying on the internal jugular vein and pneumogastric nerve. The vast majority are in the posterior triangle, many being quite deeply situated near to the internal jugular vein. The spinal accessory nerve was found between two large glands and was carefully dissected out and saved. A few smaller glands were taken from the anterior triangle just below the jaw. Ultimately *no less than forty-eight glands* were removed." It was a long and tedious dissection. If you attack these glands when they have once gone on to suppurate I cannot tell you how long you will have to take in removing them. I have found difficulties quite as great from suppurating tubercular glands as from old malignant glands. When they have become adherent to the deep structures you have to dissect them from the veins and arteries. Last year I removed some glands from the axilla which had long been suppurating, and before I completed the operation I found that I had removed not only the

axillary vein but also divided the axillary artery. The patient, however, recovered completely. It was a tubercular gland case and it shows you how the deep structures may be involved and what there may be before you. In cases where the glands are not suppurating, in the early stages you can turn them out one after another and thus clear out the neck. Nothing could be more satisfactory than the result of the operation upon this woman. The report is an exceedingly good one by Mr. Musson. There was very little more to say after describing the operation. "The wound was sewn up with horsehair. No drainage was left at all. The wound was dressed with gauze and primary union was obtained." Here is the chart showing no temperature above 99° after the operation. Before the operation the temperature was 99·6°. A slow inflammatory process in connection with tuberculous glands will often keep the temperature between 99° and 100°. Having removed the whole of the glands we obtained primary union, and if the patient be afterwards placed under favourable circumstances we hope that she will have no further trouble of the kind. But a woman once attacked with tubercle ought to be exceedingly careful and live as much as possible in the open air. If this woman returns again to this neighbourhood we may possibly have further operations to perform upon her.

I need not, I think, go here into the pathology of this condition. I have discussed the way that the glands get infected. What you find if you examine any tubercular glands that have been excised is that when you cut them across they show almost invariably yellow caseating masses in their interior. Supposing this (represented on blackboard) is a section of a gland, you find these yellow, rounded masses in its interior, which show fatty degeneration of the inflammatory material excited by the tubercle bacillus, and round that you see little grey or white spots caused by the miliary tubercles. Sometimes you find two or three of these in one gland, and you will see as they enlarge they grow together (like this). In the majority of the glands affected, on section you will find this degenerative process going on. It is a fatty degeneration of the inflammatory materials thrown out by the tissues to protect themselves against the bacillus. This yellow caseating tubercular matter is dead material. If you examine it microscopically you will never find any vessels in it. In this way the tubercular deposit differs from syphilitic deposits, as these have vessels penetrating into them. The tubercular deposit is extravascular.

You will find, on section of the grey tubercular material, giant cells and round epithelioid cells, and a large number of leucocytes. Supposing these glands to have gone on to suppuration, it becomes a question then whether you should attempt any excision or not. I have told you of the trouble you may get into if the suppuration has gone on for some time and the glands become adherent. Generally, when suppuration has taken place, we content ourselves by opening the abscesses and removing the interior of the glands with a Volkmann's spoon. In that way you will get excellent results, but you are more liable to get glands in the neighbourhood infected afterwards owing to the tubercular matter not having been completely cleaned out. Scraping with a sharp spoon through a small incision is a way in which it is often important to operate when you are dealing with ladies. They are very loth indeed to consent to any operation which makes a large scar. They much prefer, if there is any chance of the gland having gone on to suppuration, that you should make a small incision and scrape out the tuberculous material. It is not a bad plan to introduce some emulsion of iodoform into the cavity after scraping. I have not found it often necessary to have any drainage at all. Sometimes a little serum will collect, and you may have to put a probe through the wound to let the serum out.

There was a gentleman who when I first knew him was an apprentice to an electrical engineer. I think I operated upon him first about eighteen years ago, when I removed some glands from his neck which had gone on to suppuration. These healed up and he got well and strong. I advised him to take a change, but he came back into a heated workshop again, and again he broke down. He was

then sent to Australia and came back perfectly robust. But he is bent on engineering and comes back to his workshop and again breaks down. Next he goes to South Africa and comes back well and strong, but goes to his former work again and again fresh glands enlarge, suppurate, and have to be scraped out. That gentleman is now about the age of thirty-eight, and during the last few years he has been quite free from tubercle. At one time his lungs were threatened and he spat up a little blood. I sent him to one of our physicians and he said he could detect nothing certain in his lungs and advised him to live out of doors. That man, after all these years, is now free from any glandular enlargement and has scarcely any scar whatever in his neck. In his case the glands went on rapidly to suppuration. On one occasion there were many such glands underneath the chin, and so I was enabled to excise a considerable number at once. But now I believe he is a perfectly sound man. You must not despair though a man may have been weakly in his youth. When he gets on to the period of middle life he may be a strong man, and even live to a good old age. The last thing that I know of this gentlemen is that a few weeks ago I signed a certificate as to his health. He is contemplating matrimony and his fiancée and her father were desirous of nowing if his constitution would bear the cares and responsibilities of married life. My opinion was that if their means allowed him to take long holidays, and rest from work, his constitution was sufficiently strong, but not if the future of the family depended on his exertions alone.

LYMPHOSARCOMA OF THE NECK.—I now pass on to the other case, and contrast it with the case of this young woman of twenty-three. This patient is a man of fifty-seven years of age, a labourer living in Norfolk. We have here a very rapidly growing tumour of the neck. He, too, has a wonderful family history, from what the ward clerk tells us. This is one of Mr. Dyson's reports. "The patient does not know of any disease in his family. He has never had any illness in his life." Each case, you see, has a remarkably sound family history. But note the difference when you come to the duration of this man's disease. "*Six weeks* ago the patient first noticed a small swelling in his neck. It commenced behind near the margin of the trapezius, and the swelling was quite hard. It did not trouble him much at first, but gradually got larger. It was not painful, but inconvenienced him, and so he went to the doctor. The doctor told him it was a tumour, and advised him to come to the hospital. The swelling has extended now from over the sterno-mastoid down to the clavicle."

On admission. — "The patient has a large swelling on the left side of the neck. It extends from the level of the angle of the jaw down to the clavicle, and from the anterior border of the sterno-mastoid in front to the anterior border of the trapezius behind. The swelling does not appear to be connected with the clavicle and extends round the posterior border of the sterno-mastoid. The swelling is hard to touch and shows no fluctuation, is of uniform consistency and slightly movable. The axillary glands are not swollen, and the skin over the swelling is normal and not adherent. The temperature is 99·6°." Here is a very curious thing. This woman's temperature was 99·6° and she was suffering from tubercular glands of the neck. Here is another affection of the neck of quite a different character and on admission this man's temperature is also 99·6°. I notice another curious thing—and there is no collusion here, because they are different reporters. This woman's urine was yellow with a sp. gr. of 1008 and acid. The man's urine had a sp. gr. of 1008 and was pale.

On examining the man we also found a small nodule in his liver. The registrar says, "The swelling is somewhat boggy to touch and deeply fixed. It does not move on swallowing, and is not therefore connected with the thyroid gland." Here is a tumour involving the whole of the posterior triangle and nearly all of the deep structures in the neck. We made a diagnosis of lymphosarcoma. We know that the sarcomatous growths which occur in this region are frequently developed in connection with lymph-

atic glands, and grow rapidly, and are among the most malignant growths that you have to deal with. We suspected that he might have some secondary deposits, and his liver was examined and a nodule found. Though this man had been a perfectly sound man until six weeks before we saw him, it was a question whether we ought to operate upon him. I wrote to his doctor who sent him up, and told him that he had sent me a very serious case to deal with, and that I was a little doubtful whether it might not be already too advanced for me to give him any great relief. He replied, "I always like to send you up something that you may have a little difficulty over, and I shall expect you to do the best you can for the man." Under the circumstances, after due consideration, we undertook this operation to prolong the life of the man, and save him from distress and pain, even though he might have already a slight nodule in his liver. It was quite evident that this mass in his neck would soon ulcerate through, and he would have a fetid horrible fungating growth there, which would soon kill him. We operated on the 4th August. "A.C.E. was administered. An incision was made about five inches long, obliquely downwards and outwards across the growth. The incision extended from just below the angle of the jaw to the outer part of the clavicle. The external jugular vein was then ligatured and divided. The skin and superficial fascia and platysma were then dissected off the growth, and the margins of the latter clearly defined by separating from the surrounding structures with a blunt dissection. The posterior margin of the growth was then raised, and its attachments to the deeper tissues were divided with a pair of scissors. Anteriorly it was detached in the same way. At the lower part it was lying in close relation to the brachial plexus, and great care had to be exercised in detaching it from these cords. During the operation the patient's pulse became very weak, and an injection of strychnine had to be given. This improved the pulse. Afterwards injections of brandy were given, and from time to time during the operation. The carotid vessels and vagus nerve were surrounded by the growth, and the dissection here was consequently rendered difficult." The whole side of the neck, from the jaw to the clavicle was laid bare in removing this growth, and then it was quite evident that the growth extended far into other tissues in the neighbourhood, and that I could not with certainty clear away everything in connection with it. The wound was closed up, and the condition of the patient did not allow of any suturing except with a few interrupted salmon-gut sutures. After this very severe operation the man did exceedingly well as soon as he recovered from the shock. The temperature rose to 101° on the following day, and his pulse which, after the operation, was about 120, gradually fell to 96. On the 10th of August his temperature fell to 99°. The wound, which was dressed on August 6th, was then completely closed and sutured, and his temperature gradually fell, so that on the sixth day it reached normal. There is very little more to say about the case. The patient was discharged on August 22nd, the wound having completely healed. "The lump in the liver appears to have increased in size during the time he has been in the hospital." We sent him out with the tumour removed and the wound healed within little more than a fortnight from the operation. The microscopical examination of this tumour showed it to be lymphosarcoma. A lymphosarcoma is one of those malignant forms of tumour in which you notice the reticulated appearance of a lymph gland tumour with large, round or oval cells of a sarcomatous nature. The clinical characteristics of it are its very rapid growth and its rapid involvement of the parts around; spreading, too, generally more rapidly to distant parts than other forms of sarcoma, but extending very rapidly into the immediate neighbourhood. If allowed to go on it quickly comes through the skin, and forms a ghastly fungating sore, with frequent hæmorrhages, and the patient is gradually exhausted and dies from the bleeding and suppuration which take place. This may be all completed within the course of a very few months. I asked my house-surgeon to enquire of the doctor how the man is getting

on, and I learn that he is still alive. He is now suffering from pneumonia (which may possibly be due to secondary deposits in his lungs), and the lump which we detected in his liver has increased in size since he has been out. The operation was done on August 4th, and I think the man's condition would have been very much worse by this time, if he were indeed alive, had not the operation been performed. It is over two months now since the operation was performed, and I think the doctor said nothing about the wound breaking down again. That is a terrible case of tumour occurring rapidly in an apparently healthy man of fifty-seven, and I brought it here to contrast it with the case of chronic tubercular glands in the neck of the other patient, the woman who, we may hope, will live for many years to come. The man is doomed to die, probably before the end of the year.

SEQUEL.—On November 5th, 1902, Mr. Lucas received a note from Dr. Pembroke Minns, of Thetford, telling him that the patient died on November 3rd, just three months after the operation, and eighteen weeks from the commencement of the disease. Dr. Minns said "There were large secondary deposits in the liver, and in the stomach also, I think. He vomited a few hours before death a considerable quantity of grumous matter and blood."

Pass List.

Royal College of Physicians of London, October, 1902.

EXAMINATION FOR THE MEMBERSHIP.

Herbert Stanley French, B.A., M.B. Oxford.

University of London, October, 1902.

M.B. EXAMINATION.

FIRST DIVISION.—R. P. Rowlands, F. E. Walker.

SECOND DIVISION.—K. Anderson, M. W. Cohen, M. Abdy Collins, G. Evans, E. C. B. Ibotson, T. A. Matthews, W. G. Mumford, S. J. Ormond, C. H. Robertson, G. S. Robertson, F. L. Thomas.

In the Medical Wards.

FIVE CASES OF INTUSSUSCEPTION.

The following five cases were admitted into Clinical during the last six weeks, and are of interest. Speaking as an onlooker, there are two schools of treatment: those who rely on inflation, repeated if necessary, and on operation as a last resort; and those who rely on abdominal section, with or without inflation; and, of course, others combine these alternatives. The cases came under different authorities, and are therefore less easy to contrast, and so are published without much comment. The arguments briefly, are—on the one hand, that inflation, even as often as three times, has produced cures; and, on the other, that operation, with simultaneous inflation, has revealed *irreducible* inflations and intussusceptions, and that operation after previous anæsthesia results fatally from the exhaustion of successive failures to reduce, and is not incident on the operation itself; but the cases are published more to illustrate what *is* being done than any theory as to what *should* be done.

G. J., aged six months, admitted for passing blood per rectum. The child had been perfectly well up to thirty-six hours before admission, when it seemed to be in pain and shortly afterwards passed some blood and slime per rectum. The child refused all food, and as the passage of blood continued, he was brought up and admitted.

A tumour could be felt in the abdomen, and on rectal examination a small mass could be felt high up in the rectum.

An anæsthetic was administered and the bowel inflated with milk and water; the tumour was felt to gradually recede upwards and to the right. An incision was then made on the right side of the abdomen, three inches long and about two inches from umbilicus, and the remainder of the intussusception reduced by hand—the intussusception was of the ileo-cæcal variety. The abdomen was then sewn up and the child put back to bed.

The child was fed on two-hourly feeds of milk, and later Allen & Hanbury's No. 1, as the milk disagreed.

The bowels were opened within twelve hours of the operation and the child made an uninterrupted recovery.

D. H. T.

M. T. was a healthy child of ten months, who was quite well up to the evening before admission. She then refused her food and seemed ill.

On the morning of the day on which she was admitted she was sick, and passed one yellow fæcal motion followed by several others consisting of blood and mucus. One of these was seen on admission at 12.30 a.m. She was then felt to have a curved swel ing in the left upper part of the abdomen. Two hours later chloroform was administered, and the swelling was quite definitely felt, curving from the right iliac fossa up to the epigastrium, where it terminated about the middle line in a distinct

edge. One and a half pints of milk and water were injected at a pressure of 2–3ft. The edge was felt to recede to the left, and a large mass made its appearance in the right iliac fossa. This then disappeared, and no swelling could be felt anywhere. The baby was returned to bed after an inflation lasting 30–40 minutes.

The next morning the child was better, but in the afternoon it again became sick. The motions were green and slimy, containing neither fæcal matter nor blood. A small, indistinct lump was felt in the right iliac fossa. At 5 p.m. inflation was repeated; the lump was less obvious in the inflated abdomen, but there was no improvement in the child's condition; it continued sick, and passed no fæces. At 11 p.m. the inflation was repeated for the third time. No change was noticed in the abdomen. The next motion consisted entirely of blood and mucus, the following ones were fæcal, and the child took its food well and made a rapid and uninterrupted recovery. Patient was discharged a week later.

O. W. R.

F. K., aged nine months, was admitted on October 1st for vomiting and the passing of blood and mucus per rectum. The child had been perfectly healthy until twenty-four hours before admission, when it began to vomit. The vomiting continued, and after one or two loose motions it passed blood and mucus per rectum.

On admission, the child was not collapsed at all. There was some blood and mucus on the napkin. No tumour could be felt through the abdominal wall nor per rectum.

Dr. Hale White saw the patient, and under an anæsthetic a small rounded tumour an inch to two inches long was felt in the right iliac region. A mixture of milk and water—one of milk to four of water—at 110° was injected into the rectum by means of a soft tube and funnel. A little over a pint of the milk and water was injected, the funnel not being raised more than two and a half feet. At the same time the abdominal wall over the tumour was massaged in the course of the large gut. After ten minutes operating the tumour disappeared, and the child was put to bed. It was fed on small and frequent feeds of milk and barley water. The sickness completely stopped, and within the next twelve hours it passed two fæcal motions. It continued to do well, and was discharged a week after admission.

A. H. E. W.

A. L., aged eleven months, was admitted on October 9th, for constipation and vomiting.

The child was apparently perfectly well until four days previously, when it began to vomit; the mother attributed the vomiting to some dry biscuits which were given to it instead of the milk, which its diet had been restricted to up till that day.

During the four days before its admission, its bowels were not open at all, and on more than one occasion some blood was passed per anum.

On admission, the child's face was drawn and anxious and there seemed to be a good deal of pain.

Under an anæsthetic a small lump could be felt in the right hypochondrium.

It was decided to try the effect of blowing up the bowel with milk, and a pint of milk at 110° was injected with a funnel and indiarubber tube.

Under this treatment the lump seemed to disappear, but it was hard to be certain, as the lump was a very small one and the distension caused by the milk rendered palpation difficult.

Two hours later the patient was much worse. with severe pain and almost continuous vomiting; the pulse at the wrist was almost imperceptible, and the extremities very cold.

Very soon afterwards death occurred.

At the post-mortem an intussusception was found in the small intestine, starting at Meckel's diverticulum, which had been invaginated. F. H. P.

P. C., aged five months, admitted for abdominal tumour and passage of blood per rectum.

The history given was: The child appeared perfectly well up to midnight on the 31st, when it began crying and seemed to be in pain. About six hours later the child passed some mucus and blood per rectum. This continued and so the child was brought up and admitted about 3 p.m. The child was a big, very fat child, and apparently in pain, its hands and feet were very cold.

A tumour could be easily felt in the abdomen, and on making a rectal examination a large mass could be felt.

Diagnosis.—Intussusception.

About 5 p.m. an anæsthetic was administered and the bowel inflated with milk, and the intussusception apparently reduced.

During the night the child passed a good deal of blood, and in the morning the intussusception was found to have returned, and the child was in a somewhat collapsed condition.

It was at once attempted to reduce the intussusception by inflation, but the child died during the operation.

Post-mortem.—An intussusception, three inches long, of the ileo-cæcal variety was found, with about six inches of the gut in a dark purplish condition. No signs of peritonitis.

D. H. T.

A Misleading Description.

A RATHER elderly man was operated on for epithelioma linguæ. Chloroform was given. A good deal of bleeding occurred. After the operation was completed the patient was observed to be suffering from shock. The patient never rallied and died twenty minutes after the cessation of the anæsthetic, on the operating table, whence he had not been removed owing to the dangerous state he lay in.

Death was clearly due to shock and hæmorrhage incident on the operation, but as the death occurred

before he had returned to consciousness, it was reported to the coroner. An inquest was held and a verdict of accidental death returned. A halfpenny paper rather unnecessarily prone to make sensational "copy" in matters where good taste and consideration for the relatives' feelings would preclude unnecessary comment, placarded this as a death from chloroform.

Of this it is useless to complain, but we are sorry to see, inadvertently no doubt, it has been misrepresented in the professional press.

In a letter to the *Lancet*, under the title of "Death under chloroform," occurs the following: "The patient had only been given one and a half drachms of anæsthetic. *This shows* the death was not due to an excessive amount of chloroform." This deduction is illogical and absurd, and although it is true, it is unjustified by the statement made.

He proceeds, "the path of safety lay in the dictum, plenty of air, plenty of chloroform," the connection of the latter dictum with the former sentence being undiscoverable (does he think more chloroform would have saved the patient?), and then follows two such remarkable sentences that we must quote in full.

"Every physiologist knows that the air cells require a constant supply of oxygen, as they are unable to keep a store of it locked up for any considerable time, being unstable" (an utterance the meaning of which is hidden from us). "Now, in order to accomplish anæsthesia on a minimum of chloroform, the supply of oxygen *must be curtailed* very much." (Does he imagine chloroform is given through a Clover, or how is the *air supply limited* by the anæsthetist in an operation, as in this case, on the tongue?).

"The fad for this accurate measurement of chloroform is ridiculous for another reason—namely, that a healthy baby will often take as much as a full grown person!!!"

The *Lancet* mildly comments—"Our correspondent has overlooked an important fact among others," and then rightly proceeds to demolish *every* statement made.

It was *not* a death *under* chloroform, meaning a death from chloroform, but *after*, neither was there any attempt made to give chloroform on any theory of dosage. Nor was the chloroform the cause of death. Had the operation been done without an anæsthetic and under eucaine the death would equally have resulted.

What seems a pity is that our esteemed contemporary published such an unscientific and misleading letter, only to contradict and correct every single statement in the editorial comment, and we further say that any attempt to extract useful medical facts from the necessarily unscientific coroner's enquiry, as reported by a hysterical press, is but ploughing the sands of the shore.

All medical men recognise that the conditions under which the enquiry is held are so false that the jury's verdict is absolutely unreliable from a medical point of view, though usually quite a fair statement of the cause of death from the public point of view.

Washbourn Memorial Fund.

THIRD LIST OF SUBSCRIPTIONS.

It is proposed to close the above Fund shortly. Cheques should be made payable to Dr. A. P. Beddard. The Hon. Sec. will be glad if those who have kindly promised subscriptions will now pay them to him.

The following subscriptions have been paid or promised:

	£	s.	d.
Subscriptions previously acknowledged	94	4	6
Dr. Stevenson	2	2	0
Mr. Brailey	2	2	0
Mr. G. Rowell	2	2	0
Mr. R. M. Cole...	2	2	0
Mr. E. F. H. Hardenberg	1	1	0
Mr. Owen Richards	1	1	0
Dr. E. Goodall	1	1	0
Mr. J. A. Washbourn	1	1	0
Dr. W. J. Lindsay	1	1	0
Dr. H. Cooper	1	1	0
Mr. Maggs	1	1	0
Mr. R. Beaton	1	1	0
Dr. Cleveland	1	1	0
Mr. H. M. Berncastle	0	10	6
	£112	12	0

A. P. BEDDARD, Hon. Sec.

44, Seymour Street, W.

Notices.

DEMONSTRATOR OF PHYSIOLOGY.

There is a vacancy for the above. Duties to commence on January 1st, 1903. Applications should be sent to the Treasurer, Superintendent's Office, not later than Thursday, November 27th. Particulars of the appointment may be obtained of the DEAN, Medical School Office.

ARMY MEDICAL SERVICE.

An examination of candidates for not less than thirty Commissions in the Royal Army Medical Corps, will be held on the 6th January, 1903, and following days.

Applications to compete should be made to the Director General, Army Medical Service, 18, Victoria Street, London, S.W., not later than 22nd December, on which date the list will be closed.

Candidates who are over the regulated limit of age at the date of the examination, will be permitted to deduct from their actual age any period of service in the field after 1st October, 1899, that they could reckon towards retired pay and gratuity, if such deduction will bring them within the age limit.

Passim.

The first "Smoker" of the session is announced for Saturday, December 6th, at 8 o'clock, and will, we are sure, prove a great success. It will be preceded by a house-dinner in the college library. The tickets for admission are 1s., and may be obtained from the caterer or from the Residents. The dinner will be 2s., and places must be booked beforehand. The arrangements are in the hands of Messrs. Atkins and Brydone, who will be very glad to hear of possible performers, as it is expected that members and their friends will supply all that can be desired to make the evening enjoyable. R. Clement Lucas, Esq., F.R.C.S., has kindly consented to take the Chair, and will be present at the house-dinner.

The caricature of a well-known physician in an equally well-known periodical, and his subsequent severe and dignified repudiation, formed a rather amusing incident. Without wishing to impute "unctuous rectitude," to so correct and outraged a personality, we cannot help comparing the delightful sentence, "I am told this is a distinction," with the naive and childlike remarks that drop from the lips of the learned judges at any reference to a well-known custom, personage or common slang expression made in open court. It has been said by some who perhaps had not well considered the remark (a not uncommon thing among public men), that the heads of the medical profession are rising in rank and social scale, and it certainly seems that the eminent and respected leaders of our profession are cultivating quite as dignified if somewhat perplexing a mien. *Professus grandia turget spectatum admissi risum teneatis amici?* We mean no disrespect, but the humour strikes us.

Next Tuesday the Annual Dance takes place in the court room, and we predict a great success. All the ladies' tickets have been disposed of, and unless any are not required, there will be no further issue. It is premature to say anything about the arrangements, but the alterations, comprehensive as they were, at the eleventh hour, are we are convinced all for the benefit of the dancers. Mrs. Cosmo Bonsor will receive the guests, and the stewards will, we trust, be mindful of the importance of their post.

It is a common thing for mankind to turn a kindly ear to tales of the great and glorious past, to sit in clouds of smoke in a reposed and indulgent frame of mind to listen to tales of the early doings of the now great, to hear anecdotes and accounts of vanished customs and bye-gone and abandoned practices. It is a human if a parochial trait that appeals to most, and there are few who are not attentive to reminiscences and tales of bye-gone physicians and surgeons. Therefore we predict a large and an enthusiastic audience for Dr. Savage's promised address on recollections of his time at Guy's, which will come after Christmas, and for ourselves we are always glad to print stories and memorials of the mighty dead.

In another column we have referred to the great personal loss so many recent and present students have felt and grieved over, in the tragic and terribly sudden death of Maurice Dunbar Wood, familiarly known to almost the entire generation of the last six years as "M.D." It came in addition to a deep personal sorrow as a terrible reminder of the ever present risk, and of the nearness of the Angel of Death, though alas, too often familiarity with the sufferings of the dying has blinded us to the risks of our calling.

To all comes the sickening deadening time that elapses between the chair of the examination and the list of the passed, and this time of year is to the senior men the most unpleasant time of the year. The London M.B. is just over, and the results are gratifying to us in the extreme, but of a large number the examiners were only able to allot a first division to six, of whom two were Guy's men—R. P. Rowlands and F. E. Walker—and it is not too much to say that the inclusion of two such redoubtable house-surgeons will surprise none, and give satisfaction to all. The results of the last two years had rather given rise to the belief that sound practical ability was at any rate handicapped, if not subordinated to a studious and expressive intelligence, or in other words, that

"things seen and done were of considerably less value than things read about and never seen done."

THERE is a general impression abroad that medicine is ceasing to be popular as a career, and we hear of the depression that is now prevalent, and the entries certainly show a diminution so remarkable that our own entry is a matter for legitimate pride. Taking our nearest rivals in size the figures are :—

St. Bart's	75
London	73
Guy's	72
St. Thomas's	42

St. Bart's have lost nine and St. Thomas's seven, while we have gained four and the London nine on the results of last year. Well may the Dean's face wear a contented look. Statistics are invariably unsatisfactory and so we will not lay stress on the figures, but we should like to compare these with those of the Scotch and Irish schools, whose competition the ban of long and expensive training has felt rather severely. The point is that we have held our own while most schools have lost considerably.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Medical Profession.

DEAR SIR,—I am glad to see that in your issue of November 8th you draw attention to some of the disadvantages of medicine as a profession by which one can earn one's daily bread with a respectable layer of butter on it. At this time of the year one is surfeited with the eulogies and platitudes which greet the novice at the commencement of his student life, and it is refreshing to turn to a plain statement of some of the objections to the practice of medicine as a career.

I would entirely support you against the writer of the article in *The Guardian* as to the cost and duration of a medical education. To give an instance: Of all those who entered with me on the London University course as "Preliminary Scientific" Students, none qualified M.B. in less than six and a half years, and of those who were successful and did resident appointments, none finished them and started in the world on his own account until a year later. Without undue pride, I think we can be taken as a very average lot as regards ability, and the length of time we took is more often exceeded than shortened. A man who seeks a medical degree, and who wishes to do house appointments, must therefore expect to spend at least seven and a half years before he is in a position to ask his father for a thousand pounds with which to start in practice. As to his cost during that period I quite agree, from experience, that £160 a year is none too much to allow, unless he can live at home, and even in the latter case he will, if he wants to take any part in the life of his fellows, find that there are many little extras which make a liberal allowance necessary. But after these matters have been considered and decided on, and he has done his appointments and gained his degree, he will then commence a very different life, and he has to face the answer to the question which could not be answered when he left school: Will he like his profession as a means of earning his living? Apart from a dislike or a liking for the study of disease—a point which a few years at a hospital will soon decide—will he find that the practice of medicine fulfils his expectations as an honourable and gentlemanly profession?

In order to answer this question let us examine, firstly, his social position as a doctor in practice, and secondly, the character of the work which he will be called upon to do.

There can be no doubt that the medical profession is an extremely mixed one, and people of good breeding and education cannot be blamed if they judge the newcomer in the light of their experience of his colleagues in the neighbourhood, and though the social position of a doctor is to a great extent dependent on himself and *his wife*, he will find that wherever he settles he will be on an equality with a class of men which he was careful at his public school or university to hold aloof from. That this is also true of the Law, and to a certain extent of the Church, cannot be doubted, but I would quote in support of my contention that socially a man gains nothing from the fact that he is a doctor, the relations of the medical to the combatant branches of the services. Here the one has often to suffer for the lack of breeding and good manners of the many, and the young surgeon has to prove himself a gentleman before he is accepted as such. The little leaven does not unfortunately leaven the whole.

Then, as to the work he will be called upon to do. Nearly every practice nowadays includes some club work, and it has been recently said by one of the profession that club work is demoralising and degrading; there is also much low fee work done, which many may find hard to reconcile with their conscience. It is galling, too, to have to attend people who think that for three and sixpence they are entitled to treat you as a servant.

The bickerings and jealousies of rival practitioners, the underserved abuse often heaped on the doctor by ignorant people, the success gained by humbug, all these may be found in any profession, but especially in the

medical, and though I would not suggest that all the work the young practitioner is called on to do is of the nature to which I have referred, and of which the poorer class of practice is mainly composed, yet there is enough of a character to which an honourable and scrupulous man must take exception. A man who has sufficient money to enable him to pick and choose, either by buying work of a good class, which is necessarily costly, or by living on his means until the right sort of practice comes to him, will probably avoid what another, who is forced to earn his living at once, is bound to accept or starve.

There is a popular impression, and it has to be reckoned with, that a man having acquired the art of healing and aiding the sick ought, from dictates of humanity, to exercise such power whenever an opportunity offers irrespective of substantial reward. People lose sight of the fact that the great majority of men take up medicine for a livelihood and not as an outlet for their philanthropic instincts. One constantly sees at inquests and in the law courts what a great amount of work is expected to be done, indeed, has to be done, for nothing. What with fees that are no fees, charity work and bad debts, many a man only gets seventy-five per cent. of the money he has earned. What lawyer can say that? The reason for much that is out of joint in the medical life at present is that men have been sent into it who are quite unfitted for it, men of little education, little knowledge and no means, have found that earning a living is hard work, and consequently have resorted to tactics that are discreditable, and the cutting down of fees has in this age of competition flooded the market with cheap goods to the detriment of the better article and the purchaser.

Possibly some think that by entering a profession they are gaining a position and a living to which there is more "prestige" attached than to trade, banking or other commercial calling. As regards the medical profession, this is quite a mistake, and the doctor's brass plate confers no more distinction than the wholesale shop-window or the riverside wharf bearing the owner's name. Then one hears, too, a great deal of the interest of our profession. Certainly it is interesting, but in that most fascinating of all studies—the study of human nature—can the doctor claim a greater experience than the lawyer or the magistrate?

That there is much that is quite erroneus in the popular estimation of a doctor's life, is a point which I think ought to be insisted on more strongly, and the doing so might save many a man from wasting time and money on entering a profession for which he finds too late that he is quite unsuited.

A SUCCESSFUL PRACTITIONER.

[The writer of the article in the *Guardian*, we have reason to believe, is a member of the St. Thomas's staff.—ED.]

Guy's Chapel Services.

DEAR SIR,—I may say that I have been accustomed to good choir-singing, and am, therefore, not altogether inexperienced in church music. In addition to having been honorary choir-master of my parish church, I was, when formerly in practice in London, a deputy in the professional choirs of Westminster Abbey and St. James' Chapel Royal—I suppose, by-the-bye, I was the only Guy's man who sang in our King Edward's Special Coronation Choir, as well as at his dear old mother's Jubilee.

I shall never forget the Chapel "Choir"; the "singing," and the usual style of services as performed from about 1866 to 1870

Nor shall I forget my recent visit to the Chapel. I was amazed at the contrast! The heartiness of the singing was the most congregational I think I have ever heard; and, to me, a great treat. I consider it reflected very great credit on all concerned. The soprano and contralto voices of those "ministering angels" were delightful; up to pitch and evidently well trained; and I cannot say less as regards the men's voices. All the parts were well balanced, every word clearly enunciated, the *pointing* of the Psalms excellent, and the whole service, from a *musical* point of view, well rendered.

There have been many transformation scenes at Guy's since my time; but it struck me that the improvement in the Chapel service was quite in keeping with all the many other most excellent changes in and about the dear old place. I confess I went on the Sunday night chiefly out of curiosity, and I listened with intense admiration; and, if opportunity permits, *I shall listen again.*

I beg to enclose my card. Therefore, kindly allow me to subscribe myself only,

A VISITOR.

Nov. 17th, 1902.

Somewhat Lighter.

HE was a Clinical Assistant with a knack of quotation and parody which some mistook for a familiarity with English Literature, and as he wandered down to the necropsy of the chronic case whose abundance of physical signs and irreconcilable symptoms had been the joy of the physician and the horror of the clerk and source of much diagnosis, he was heard to mutter as he listened to the rather guarded prognostications:—

We are backing down on the old case, the out case,
The long case—the case that we all knew,
Where the blindest bluffs hold good, dear lass,
And the wildest tales are true.
And men loom large on the old case, the out case,
The case that was always *new*.

GLAUCOPIS.

Guy's Hospital Physical Society.

A MEETING was held on Wednesday, November 5th, in the College, Mr. A. C. H. Gray in the Chair.

Mr. P. R. Bolus read a paper "On Hypnotism." He traced the history from the time of Mesmer, who frequently induced the condition of hypnosis, down to recent times, dwelling more particularly on the work of Braid, and the schools of Nancy and Paris. The subject was further considered under the following headings:—Types of the hypnotic state; classification of and the methods for inducing hypnotism; the phenomena of suggestion; muscular and other phenomena; post-hypnotic suggestion; comparison of hypnosis with cognate states, stages, etc.; the theories to explain hypnosis; the therapeutic causes of hypnosis; the danger that may attend the induction of hypnosis; the susceptibility of those who are in ill health; children and the insane.

Mr. BLAKE-ODGERS asked whether anyone could practice hypnotism, or whether some special powers were required.

Mr. MANN.—Is crime possible in the hypnotic state? Bramwell has stated that it is not. He further wanted to know what operations Mr. Bolus had seen performed under its influence.

Mr. OWEN RICHARDS thought that post-hypnotic suggestion was of great importance, and a cause for the distrust with which hypnotism was regarded. He instanced a case in Paris in which murder was attributed to this cause. Men who have practised it have done so much to discredit themselves that it is not surprising that discredit is thrown on this subject. He gave various cases in which the experiments were shown to be elaborate frauds, and even scientific men had been taken in by them. The great difficulty that has always surrounded the study of hypnotism is due to the fact that it is so open to fraud.

Mr. LARKIN wished to know whether Mr. Bolus had ever seen anyone under the influence of hypnotic suggestion. Is it necessary for the same person who hypnotised the patient to bring him round again?

MR. SPRIGGS said that the question had been raised in New York of limiting the practice of hypnotism to those who had had five years' training.

Mr. ROBINSON.—Does the operator possess any influence over an individual who has been once hypnotised by him, when removed to a distance?

Mr. ORMOND referred to the effects produced by looking at the *fundus* oculi of animals for the purpose of making drawings. The effect of this was to induce hypnosis for periods of a half to one hour.

Mr. WILSON referred to some cases he had seen in York.

Mr. BOLUS then replied: Some people have greater power to hypnotise than others; at all events the proportion of those who can be hypnotised varies with different operators. He quoted experiments to show that crime is possible in the hypnotised state, but in reply to Mr. Mann admitted that the subject was a criminal. He had seen an abscess opened under the influence of hypnosis. It was not necessary for the same individual who hypnotised a patient to awaken him.

Guy's Hospital Debating Society.

ON the evening of Saturday, November 15th, the Smoking Room was once again the scene of a crowded and highly successful debate. The chair was taken at 8 o'clock by Dr. Fawcett, who promptly called upon the secretary to read the minutes of the last meeting; these having been read and confirmed, and no business questions, impertinent or otherwise, being forthcoming, Mr. Bell Walker was called upon to propose, "That this House views with alarm the increasing American influence in this country."

Although smitten with bronchitis, and in the throes of "take-in," the honourable proposer, nevertheless, grappled with the problem in a most able manner. He dealt almost exclusively with the financial aspect of the question. Considering American influence upon British commerce to be most potent and most deadly, he accordingly set aside all other manifestations of that influence as practically negligible. He spoke of the capture of various British markets by enterprising Americans, and deplored our passivity in submitting to the wholesale introduction of American business methods. An awestruck House next listened to his stirring condemnation of the wily Trust, it was a company of companies, an economic pitfall, embodying a principle antagonistic to all one's idea of commercial progress. He then spoke of the systematic boycotting of British goods on the part of the Yankees as shown by the McKinley and Dingley tariffs.

Again, why should the Central London Railway be an American enterprise? An English company had come forward with a scheme for the intubation of London, which, although it would have been £2,000,000 cheaper in the working, was nevertheless rejected by Parliament. Here the honourable proposer laid aside his calmly judicial tone and emphatically declared that Parliament and the L.C.C. had been corrupted by American capitalists. (A loud uproar here ensued and cries of "order" drowned the speaker, but the chairman, while at the same time he admitted that the honourable proposer was upon thin ice, nevertheless pronounced that the remarks were not libellous as no names had been mentioned.) In conclusion he solemnly warned his hearers of the danger of shutting their eyes to these influences, which, if they were not stemmed, would lead to the entire loss of our commercial individuality.

Mr. BOWLE being called upon to oppose the motion, declared that he was a very feeble person, but heaven helping him, he would not be daunted by that initial difficulty. He attacked the honourable proposer for what he styled that gentleman's egotistical and insular outlook. America was our offspring, and the honourable proposer would have us play the part of the selfish

parent. Also no mention had been made of America's literary and artistic influence, which he considered most important factors in the question. He also spoke of American science and trade in terms of praise. American competition had a bracing effect upon us, and so far as the danger of their actually supplanting us was concerned, we were perfectly able to take care of ourselves. Here the honourable opposer diverged into philosophical ruminations which had no bearing upon the point at issue. He declared that if Nature had ordained that we were to be outdone by American competition, then it was useless for us to pit ourselves against the march of events. He could speak of trusts, but he would not. He could point out the negative value of the influence of American expectoration and peculiar hats, but he would not. He declared that it was merely cowardice that prompted the honourable proposer to support such a motion as that before the House.

Mr. EDRIDGE seconded the motion.

Mr. EDEY seconded the opposition. He said that up till now American attempts to capture English markets had been failures all along the line. American work also was shoddy, and work that cannot stand the test of time was no serious menace to our own. (He should speak more often, and will improve with practice).

Mr. BLACK next rose amid a storm of applause, and in his sympathetic voice (which so strongly resembles notes on the instrument on which he is so skilful a performer), warned the House against marriages with American heiresses.

Mr. MANN thereupon tripped into the middle of the floor of the House, with a steely glint in his eye. At intervals during his speech he did a slow "cake walk," which he said he had learnt in New Zealand, and which he was sure would convince all supporters of the proposition of the greatness of the Empire. He spoke of recent shipping combines as ghastly failures, and roundly attacked the honourable proposer for confining his remarks to American influence in this country only.

Mr. FELTON next made a short speech in support of the opposition.

Mr. RUSSELL made a few preliminary remarks on malignant growths. He attacked Mr. Mann's statement that the Colonies were well able to hold their own against America, and cited cases where, in New Zealand, American engineers had replaced those of this country. Mr. Mann here attempted to divert the speaker's attention by another "cake walk," this time a rapid one, but Mr. Russell stuck to his guns, and told the House a funny story about some Chinamen who were thrown overboard free of charge.

Mr. THOMPSON said that he had never listened to so variegated a debate. There had been pessimism from the proposer, optimism from his opponent, while Mr. Edridge had reminded him of an hysterical woman at an inquest. He accused the honourable proposer of a tendency to too profuse quotation from Tennyson, whereupon that gentleman rose and asserted that since he was sure Mr. Thompson had never read a line of poetry in his life, it was quite obvious that he could not be expected to recognise Tennyson when quoted; as a matter of fact, the quotations were from Emerson. Mr. Thompson pointed out that combination was not competition, and that an American commercial invasion of this country would at least purge us of our laziness and conceit.

Mr. ALLEN had personally observed American competition both in New Zealand and in Australia, and could vouch for it being very keen. For instance, alteration in the gauge of Australian railway lines were found to be necessary shortly after Mr. Allen had left that country. These had been declared to be impracticable by English engineers, who sent out a leisurely answer by steamer. An American company promptly cabled that it was able to cope with the difficulty—and proved itself in practice as good as its word. There was a surprising lack of alertness about English workmen, and he hoped that America would temporarily harm our trade, so that we might "consider her ways and be wise."

MR. PALMER contended that the honourable opposer, having "no case," had sought to cover the lack of one by thinly-veiled abuse of his opponent. He considered American influence detrimental, firstly, because it fostered a false economy, many people buying cheap American goods which would not stand even ordinary wear and tear, and secondly, because of the deplorable want of taste engendered by Yankee business methods. Americans were responsible for those most gruesomely-inartistic advertisements which cover our hoardings.

MR. DONNELL propounded "a paradox, a paradox, a most ingenious paradox." If we could perceive the danger from America, it did not exist; but if we could not see it, it had a very real existence.

MR. BOWLE declined the privilege of replying, because, he said, the eloquence of his supporters had made a reply unnecessary.

MR. BELL-WALKER, in replying, declared that questions of literature and art, expectorations and peculiar hats, were all beside the point. Also, what had Mr. Russell's Chinamen got to do with American influence?

The motion was then put to the vote—

For the motion...	31
Against	18
Motion carried by majority of	13

A vote of thanks to Dr. Fawcett for presiding terminated a very interesting debate.

WILLIAM H. W. STRACHAN, Chief Medical Officer of the Colony of Lagos, is nominated a Companion of the Order of St. Michael and St. George.

DR. LAURISTON E. SHAW has been elected Honorary Secretary to the Faculty of Medicine in the University of London.

University of Oxford.

EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

SECOND EXAMINATION.

Wednesday, December 3rd. Examination Schools.
9.30 a.m.—Principles and Practice of Medicine.
2 p.m.—Principles and Practice of Surgery.
Thursday, December 4th. Examination Schools.
9.30 a.m.—Midwifery and Diseases of Women and Children.
2 p.m.—Pathology.
Friday, December 5th. Examination Schools.
9.30 a.m.—Forensic Medicine and Hygiene. Medical Department, Museum.
2 p.m.—Practical Examination in Pathology, and viva voce.
Tuesday, December 9th. Radcliffe Infirmary.
9.30 a.m.—Clinical Examination in Surgery. Written reports of cases and viva voce at bedside.
Thursday, December 11th. Radcliffe Infirmary.
10 a.m. & 2 p.m.—Clinical Examination in Medicine. Written reports of cases and viva voce at bedside.
Friday, December 12. Medical Department, Museum.
9 a.m.—Practical Examination in Medicine, Surgery, and Midwifery, and viva voce.

The Secretary to the Boards of Faculties gives notice that the Names of Candidates, accompanied in each case by a Certificate dated and signed by the proper officer of a College or Hall, or the Censor of Non-Collegiate Students, stating that the Candidate's name is at that time on the books, must be transmitted to or given in at his Office in the Clarendon Building, not later than 10.30 a.m. on WEDNESDAY, NOVEMBER 19th, 1902.

The Statutable Fee — Organic Chemistry, Materia Medica or Pathology, 16s. each; the remaining Subjects, in either Examination, £1 11s. 6d.—must be paid on entering the name.

Candidate's whose names have not been received by the above-mentioned time can be admitted to Examination on payment of an *additional* fee of Two Guineas, provided that their Forms and Fees reach the Secretary at his Office before noon on FRIDAY, NOVEMBER 28th.

Candidates in Organic Chemistry or Materia Medica and Pharmacy must have passed the Preliminary Examination in Chemistry; but any Candidate who has obtained a First or Second Class in Chemistry in the Honour School of Natural Science is exempt from Organic Chemistry. Candidates also who had passed all the Examinations for the Degree of B.A. before the end of Trinity Term, 1886, and who were registered as Medical Students on or before March 16th, 1886, are exempt from Organic Chemistry.

In the Final Examination all Candidates (including those who offer Pathology only) must have passed the several Subjects of the First Examination, viz., (1) Organic Chemistry, (2) Materia Medica and Pharmacy, (3) Human Anatomy, (4) Human Physiology.

J. S. BURDON-SANDERSON,
Regius Professor of Medicine.

Obituary.

Maurice Dunbar Wood.

On Saturday, November 15th, Maurice Dunbar Wood, æt. 26, M.R.C.S., L.R.C.P., died at Huntingdonshire General Hospital, of an acute septicæmia, infected probably by dressing the House-Surgeon, whose place he was temporarily filling, and who himself had been infected at a post-mortem on a patient. No abscesses formed, and he rapidly sank during a four days' illness, all treatment, operative and otherwise, proving of no avail. He was buried at Huntingdon, followed to the grave by the Mayor and other citizens who sympathized with his relatives on so sudden and tragic an end.

He was educated at Sherborne and entered at Guy's in October, 1894. He read for Preliminary Scientific subjects, and he soon gained a place in the Hospital XV. His keenness on football, indeed in any manly sport, lasted through the whole of his all too brief career. He gained a certificate for dissection for the Arthur Durham Prize, 1896. In June, 1898, he entered the wards and dressed to Mr. Golding-Bird, for which he earned "extension" and a good reputation. He was successful in his first application for "Clinical" in October, 1900, and qualified in July, 1901. He had not made up his mind as to his future career, but took several temporary appointments outside, and we believe at the time of his death was contemplating entering the R.A.M.C.

He was widely known to all at Guy's between 1896 and his death, as a man of good heart and good breeding, had a strong, well-built frame, and his health and spirits were splendid. He was well known as a Rugby forward, and represented Guy's at the "weight" and "hammer," and he was a great acquisition to the society of any place. He was a type that we are proud to produce and can ill spare, and perhaps the most striking tribute to his memory was the very evident pain and surprise that the news of his sudden death gave to so many of his acquaintances, as well as to his many friends. His character was strong and upright, he was straightforward, outspoken and honourable, and his death leaves the world the poorer for a single hearted gentleman. We believe that, like Fitz-Hugh, he was an only son. R.I.P.

ERRATUM.—"Reviews."—Medical Monograph: Anæsthetics. The author was J. Blumfeld, Esq., and was published by Messrs. Baillierè, Tindall & Cox.

Wealth.

THE fine sentiment of the maxim "C'est l'amour, l'amour, qui fait le monde au rond," is not re-echoed by its companion in lingo, "Amour fait beaucoup, mais argent fait tout," and whether the tender passion is responsible for the rotary motion of the earth or money is of precedent power, is a question for individual opinion. Brushing aside aphorism, very few will go so far as to deny the potency of money; and although the acquisition of worldly gain may be regarded by some as a cardinal sin, the majority of mankind, it is conceived, have not yet added this to the already too long list of transgressions.

The uncompromising attitude of the Scriptures towards wealth may in part account for arguments adduced to show the vanity of riches, but like Pink Pills and Problem Plays they fail to convince; but at chapter and verse we shake our head, and without shriek or cry of lamentation resign soul and body to the flames of uncharitable fancy.

Wealth has been the goal of humanity from time immemorial; and the progress of civilization has not slaked the thirst which the bare suggestion of money imparts; it has rather increased than subdued this unquenchable desire. At the Fountain of Fame and Wisdom, men drink deep; sacrifices are undergone; health is impaired; but at the Fount of Riches, kinship is forgot, honour trodden underfoot, death even courted!

Mighty Mammon rears his stature above all until it is lost in the clouds; and for fear of mislaying ourselves in those vaporous regions we will continue in another mood.

Money has been stated to be the root of all evil. This is one of the very wide generalisations framed by weak-kneed epigrammatists, upon totally insufficient data; do not sloth, envy, and a dozen other vices turn green with envy at this most unwarrantable preferment? Granted, it may be *the root* of some evil, but botanically the figure is hopeless, as it is inconceivable to have generated by the same descending axis, some of one thing and some of another. Money in our allowance may be an instrument for good or evil, according to the intent or disposition of its possessor; but to unreservedly asperse it because in some instances it is applied to vicious and prodigal uses is an immoral ineptitude.

We will now turn to a consideration of a few matters bearing directly or indirectly upon wealth. Many methods have been discovered for the rapid acquisition of gain, and from a non-moral standpoint, the American, perhaps, has come nearest to a satisfactory solution of the difficulty. Trusts, as a narrow way to individual affluence, remains unsurpassed if not unequalled; but inasmuch as we are but sojourners in the land and sooner or later must take up permanent residence elsewhere, we had best not fly to the devices of those of the Long Bow and Methodism.

In the non-moral category must be included gambling; and without employing serious didactics, still man should not waste his substance upon the vagaries of Chance. Horse-racing is essentially the bricks and mortar of castles in the air—eligible mansions are of stone—and their architects are, as a rule, the submerged tenth. The backer lives upon the unrealities of a fool's paradise; his hand-over-hand returns, more often than not, never get beyond the imagery of his own mind; and his systems, so infallible on paper, fall to pieces when brought to the test. Rather more respectable but equally uncertain is "punting" on the Stock Exchange. People who gamble for "differences" and who may never have seen a share certificate, let alone a dividend warrant, are imbued with the same fatal spirit as the men who back their "fancies" on the race-course; and in the same street—blind alley perhaps is more appropriate—may be placed every other description of gambling from toss ha'penny to state-guaranteed lotteries, the latter as a national means for raising the wind being happily confined to the Fatherland.

The line of demarcation may be very easily drawn between gaming and legitimate speculation. "Nothing venture nothing have" should be writ in the heart of every man of enterprise; and in business if headway is to be made, speculation to a more or less extent is imperative. For instance, the man who purchases a practice accepts a risk; he may discover that the coleur de rose everything assumed pending negotiations pales appreciably after residence and that puffy dowagers are dinning other ears with their physical lapses; but on the other hand, he may have to thank his sense of business perspective for an income quite incommensurate with the premium paid. Gaming, then, and speculation do not convey the same meaning and the terms should not be confused.

Parsimony is the antithesis of extravagance, and both should be avoided in favour of thrift, another word for economy, though a happier one. Your present-day Crœsus is not recruited from the ranks of the Scroodges and Harpagons, and the man who fondles a penny as though it were his soul in bronze and drops a tear at its loss is not a person worthy of emulation. The saving of pence in the hope that the pounds may accumulate of themselves is very doubtful economy; many a man finds it better to take care of the pounds and assume an attitude of supreme indifference towards the stivers. Never to squander anything of higher value than copper should mean absolute security from the wolf; it is when the auriferous coin is flung around that the dread yelp is heard at the door.

Extravagance is more fatal to wealth than parsimony, and, although from a worldly point of view it may be less censurable, its evil is of greater effect, and accordingly rash and unnecessary expenditure should be rigidly excluded from life's agenda. The annals of Carey Street are, for the most part, written around monetary excess, and although it does not follow that because a man's name appears in the *Gazette* — not *the* GAZETTE— he is but reaping the tares he has sown, the unreasoning world is prone to take this view and to extend his bankruptcy not only to his estate but to his reputation. But in this connection we would point out the folly of going

to the other extreme. Extravagance is one thing, niggardliness is another, and as expenditure is the only means to the realisation of wealth, the man who lays up his treasure and never exchanges it for money's worth is, to use an oxymoron, but a wealthy pauper. It is the bleary bacchants and the followers of the "young person," the unthinking men who "booze and riot" their health and means away, that stand as woeful examples of the direfulness of waste; and although it is not always to be found in association with unregeneracy, extravagance is a counteracting influence to the acquirement of riches, and its penurious effect must inevitably be felt. But here lies the point. Innocent, as distinguished from vicious, extravagance must be judged solely from the standpoint of income, and what may be lavishment in one case may in another be the reverse. Therefore, stint not of the luxuries which tend to make life livable; for just as wealth, so far as the individual is concerned, must close its days with his, be judiciously free in its disposal, and live not a miser that others may have the sole enjoyment of your possessions when you have joined the majority.

Industry, another consideration, is of vital importance as pertaining to wealth, and, discriminately practised, is the passport to the Temple of Mammon whose exhilarating atmosphere so many must be denied. We used the words "discriminately practised" advisedly. The man who handles the plough or carries a hod may be a paragon of industry; to break the stubborn glebe or carry bricks—we do not know its poetical equivalent—is to fulfil to the letter divine vengeance by the earning of bread in the sweat of the face; but unless you are prepared to settle down to a life of unholy disobedience you must elect to be a philosopher with a refined imagination, as Dr. Primrose would say, on ninepence an hour. Industry, therefore, should be discriminate and eclectic. Again, it must be uninterrupted and not spasmodic; for to apply yourself to work one day and "knock off" the next is too incident of the demoralisation of the building trade to have in it anything of worth. Matinees and afternoon billiards with the marker are influences diametrically opposed to the proper fulfilment of business; and labour to be brought to a successful issue, must flow on with the ease and certainty of a river along a plain, not as a mountain stream with boulders to impede its course.

Whether marriage or bachelorhood is more conducive to our subject is a matter of both interest and weight. To settle the question once and for all is impossible, for the answer depends solely on circumstances. Where a man is in receipt of a fixed salary it is obvious that conjugal bliss—to give it its best complexion—must reduce his means, and instead of food, shelter and raiment for one, there are two claimants to these necessaries—and haply more than two. So in this instance marriage is akin to the undiscovered country mentioned by the Prince of Denmark, the contemplation of which may be some amends for the grunts and groans of celibacy. But should he bait for an heiress, and be successful, his transition from single blessedness to the other shore should carry with it pecuniary advancement; yet even the moneyed bride may prove an ignis fatuus, for where will the husband score who takes to his embraces an ugly annuitant and is left a widower six months after?

On the other hand, in the case of a professional man, marriage, generally speaking, is a desirable state. Every member of a profession should try to develop the bump of amity; for a large circle of friends and acquaintances means notoriety, and without this, skill will go unrewarded. For gaining this end two hearts are better than one, and a married man should have the pull over a bachelor. That your partner should make herself amenable to the race ought to be a condition precedent to your nuptials, and a girl who cares nought for company and has no conversational powers will prove, to use a rather infelicitous expression, a white elephant.

Money not requisitioned for present needs should at once be invested. At a remote period of history, increase of money by way of interest was considered unconscionable, and it was forbidden by the Mosaic law: but for the last few thousand years the doctrine of monetary barrenness has fallen into disuetude, and even the present Administration, so far as we are advised, has no intention of reviving it!

Investment may be bad; but before you part with savings the wary man weighs very carefully the risks and prospects of the intended fund, and heeds not the inveiglements of those philanthropic gentlemen who flood the earth with prospectuses of gold mines and land explorations, and through whose loving-kindness and wholehearted regard you are to receive a retiring income. People who seek channels for the distribution of superfluous wealth to save their souls from the fate of Dives' are not those who circularise the public and advertise their magnanimities in the press. For immunity from declension, or, worse still, the irredeemable state of nothingness, Consols and stocks of recognised corporations are to be recommended, but for higher return of interest ground rents are to be preferred.

That pelf and probity can exist in combination is too universally recognised to need any proof; and to refrain from concluding with a moral injunction is not so much an omission of grace as a desire to avoid platitude.

PROSIT.

South African Memorial Fund.

SIXTEENTH LIST OF SUBSCRIBERS.

Amount already acknowledged	£271	2	0
G. W. Daniell	1	1	0
Deputy Director-General A. Keogh, C.B. ...	1	0	0
H. M. Berncastle	0	10	6
P. W. L. Camps...	0	10	6
W. J. Lindsay, M.D.	0	10	6
A. J. Lawrence, C.I.E....	0	5	0
G. T. Wrench	0	5	0
	£275	4	6

Nursing News.

MATRON'S OFFICE.

Miss T. M. Whittingham, who completed her three years' training in May last, has been appointed Pro-nationary Sister of the Isolation Wards.

Nurse Levy left the Hospital on October 14th, having completed her three years' training, and takes up her duties on the Private Nurses' Staff. Probationer Cope was appointed to succeed her as Head Nurse in Mary ward.

On October 18th Nurse P. Ray left on completion of her three years' training, and Probationer Maddison was appointed to succeed her as Head Nurse in the Isolation Wards.

Nurses Hutton, Lewin and Cameron have also left the Hospital on completion of their three years' training.

On October 31st Nurse Densham was transferred to Mary, and Probationer Witchell was appointed to succeed her as Head Nurse in Bright.

On November 15th Nurse Creasy left the Hospital on completion of her three years' training, and Probationer Windemer was appointed to succeed her as Head Nurse in Bright ward.

Sport.

Rugby Football.

GUY'S 1ST XV. v. BEDFORD.

This match was played at Bedford on Saturday, November 15th, before a fair number of spectators. The weather was dull and unpleasant, the ground dry, but somewhat rough. O'Brien having won the toss, Bedford kicked-off up the hill, and play opened in Guy's territory, but, by a good forward rush, was soon transferred to the other end. The forwards, carrying the scrums and heeling smartly, gave the behinds frequent opportunities of scoring, and in quick succession three tries were gained by the Hospital. The first was the result of smart play by Louisson, McEvedy and O'Brien, which led to Morgan gaining possession, and, after a good run, scoring well out. The second fell to O'Brien, and the third to Alcock from a scrimmage on Bedford's goal-line. All the kicks, taken by Tolhurst, Harrison and O'Brien, failed.

Unfortunately, in gaining the first try, Morgan's ankle gave, necessitating his retiring to full-back, and Harrison taking his place on the wing.

Continuing to press, Saunders and Anderson were conspicuous in a good forward rush. O'Brien essayed to drop a goal, and with McEvedy running strongly, another try was only spoiled by Alcock badly fumbling the ball, a similar result attending a good bout of passing by Willan, O'Brien and McEvedy a few minutes later. An intercepted pass led to play in the Guy's twenty-five, but danger was relieved by Glendinning finding touch. From the line-out Anderson broke away, and well backed up by Tolhurst, Ward and Pinching, carried the ball into Bedford's twenty-five. Following some loose and uninteresting play in mid-field, Bedford, through a misunderstanding, were permitted to run in and score behind the posts, a goal resulting from the kick. Half-time:—

GUY'S ... ... 3 tries (9 points)
BEDFORD ... 1 goal (5 points).

On resuming, O'Brien took Willan's place at half, the latter going on the wing, and Harrison taking O'Brien's place in the centre. The standard of play, which had degenerated considerably towards the end of the first half, did not improve in this. Alcock made several strong runs, from one of which he scored well out; the kick failed. Anderson, Ward and Pinching were seen to great advantage out of touch, and tackled excellently, but the heeling about this time was lamentable, and Bedford repeatedly got the ball and carried the scrums. Morgan, from full back, made several good runs, gaining much ground, and made one good attempt to drop a goal with the left foot. A bad kick by Bedford across the field was well gathered by Willan, who raced in, scoring far out. The attempt by O'Brien to convert went wide. From a penalty kick against Bedford a few minutes later, close to the touch-line, a magnificent effort to drop a goal by O'Brien only just failed. A free kick for off-side brought Bedford relief. Guy's, however, were soon again attacking, and O'Brien scored a good try close in; Harrison failed with the kick. No side soon followed. Result:—

GUY'S ... ... 6 tries (18 points)
BEDFORD ... 1 goal (5 points).

REMARKS.—The form shown by the team as a whole was certainly disappointing, especially that of our outsides. The forwards after the first ten minutes, during which they carried the scrums and heeled well and smartly, were seldom together. Considering the comparatively light pack we had against us, and the way, in the second half, Bedford at times got the ball and carried the scrums, it is obvious more than one member was not doing his share of work. It would be to the advantage of the team if these members expended more energy in this direction, even at the expense of some of their brilliance in the loose. The heeling was slow, and frequently the ball stuck in the second row.

At half, O. V. Payne is greatly missed. Willan, although doing his utmost and working hard, is scarcely up to the high standard of our last year's backs. Louisson played a good game.

Of the three-quarters, Alcock, especially in the first half, and McEvedy were not at their best. Harrison took his passes well and ran strongly.

Morgan at back, was, of course, greatly handicapped by the injury to his ankle.

From our score—6 tries—it will be seen that we sadly need a reliable place kick. The tackling on the whole was a distinct improvement upon that seen in the Richmond match, but the tendency to go high for a man is still present with some. Team:—

GUY'S.—E. M. Harrison (back); E. Morgan, A. O'Brien, P. F. McEvedy, F. Alcock (three-quarters): R. Willan, W. G. Louisson (half-backs): R. G. Anderson, B. Glendinning, E. L. Ward, E. H. Milsom, S. M. Saunders, A. M. Tolhurst, W. G. Pinching, T. B. Layton (forwards).

GUY'S HOSPITAL A v. BECKENHAM.

Played at Honor Oak Park, on Saturday, November 15th.

Guy's won the toss and played with the wind. In the first five minutes, Beckenham, with a forward rush, scored a try far out, but failed to convert. Play remained of an even character, but at the latter part of the first half we invaded our opponents' twenty-five. J. T. Hicks neatly dropped a goal. Thus, at half time, Guy's had a lead of one point.

In the second half the superior combination of the Beckenham forwards began to tell, and they scored one goal and two tries. So the game ended up, Beckenham 1 goal 3 tries—14 points. Guy's, 1 dropped goal—4 points. Team:—

GUY'S.—Husbands (back); W. H. Burney Helyer, C. Reinhold, L. Pallant (three-quarter-backs); F. Cutler, J. T. Hicks (half-backs); K. Bridger, H. Watts, M. A. Collins, H. M. Clarke, H. Stuart, F. Hogarth Kidd, M. Ball (forwards).

Association Football.

GUY'S v. KENLEY.

SURREY SENIOR CUP (2nd round).

This match was played on Saturday, November 15th, at Kenley, and after a fast and closely-contested game, resulted in a victory for Guy's by 4 goals to 2. Kenley won the toss, and immediately went off at a great pace, which was maintained almost up to the finish. Play was very even, but our opponents were the first to score from a well-placed corner. Soon after, from a good pass by Litchfield, Barber equalised, but shortly before half-time, Kenley obtained a second goal from a low shot, which Collins almost saved, the ball just going over the line, and the teams crossed over with the score 2—1 in our opponents' favour.

The second half was very exciting, and both sides looked like scoring on several occasions, Guy's having rather the best of it, and from a corner-kick Fothergill headed the ball into the net and made the scores level. As no further scoring took place, an extra quarter of an hour each was agreed on, in the second moiety of which Guy's obtained two more goals by Fothergill and Norton, our opponents palpably tiring. The centre-halves on either side played a great game, and were well supported by the other members of the team, Collins being very safe in goal. Team:—

GUY'S.—Berry, Litchfield, Barber, Norton, Fothergill (forwards); Zorab, Denning, Frankenburg (half-backs); Edey, Jones (backs); Collins (goal).

United Hospitals Hare and Hounds.

Match v. South London Harriers, run at South Croydon on Saturday, November 8th, resulted in a win for the former by 22 points to 33. Places and times as follows:—

			M.	S.
1.	J. G. Gubb	Bart.'s	29	57
2.	F. A. Knott	S.L.H.	30	10
3.	O. S. Norton	Guy's	30	11
4.	G. A. Simmons ...	St. Thomas's ...	30	30
5.	P. W. Warner	S.L.H.	30	36
6.	P. Gosse (capt.) ...	Bart.'s	31	20
7.	H. E. M. Martin ...	S.L.H.	32	1
8.	G. W. Lloyd	Bart.'s	32	15
9.	E. Gavin	S.L.H.	32	17
10.	P. Titley	S.L.H.	32	27

Five mile course. Trail layers, Messrs. R. E. Wilkes (S.L.H.) and T. Crafter (Blackheath Harriers). Timekeeper, Mr. F. N. Wyborn. Judges, Messrs. E. C. Innes and H. D. Thomas.

Appointments.

CIVIL.

MOTTRAM, GUY N., M.R.C.S., L.R.C.P. Lond., has been appointed District Medical Officer of the Williton Union.

WORTHINGTON, H. E., M.R.C.S., L.R.C.P. Lond., has been appointed District Medical Officer of the Isle of Thanet Union.

NAVAL.

Surgeon NORMAN L. RICHARDS, R.N., has been appointed to the *President* for a three months' course of hospital study.

Surgeon STANLEY S. H. SHANNON, R.N., has been awarded the silver medal and £10 worth of books on the termination of the session of special instruction at the Royal Naval Hospital, Haslar.

Births.

HOPE.—On October 22nd, at Church Street, Caversham, the wife of W. B. Hope, L.R.C.P. Lond., M.R.C.S., of a son.

McGAVIN.—On November 9th, at 21, Montague Street, Portman Square, W., the wife of Lawrie McGavin, F.R.C.S. Eng., of a daughter.

Marriage.

SHELTON-JONES—MANCHESTER.—On November 12th, at St. Peter's Church, Pwllheli, by Canon E. T. Davies, B.A., assisted by the Rev. T. Lewis, B.A., Ernest Lloyd Shelton-Jones, M.R.C.S., L.R.C.P. Lond., Erylfryn, to Lucy, third daughter of T. L. Manchester, Esq., Westfield, Pwllheli.

Deaths.

BUDD.—On November 4th, at Worcester, Herbert Goldingham Budd, M.R.C.S., L.R.C.P. Lond., aged 58.

TRUMAN.—On October 31st, at Carrington, Nottingham, Edgar Beckit Truman, M.D, St. And., M.R.C.S. Eng., L.S.A., aged 63.

ED.—J. M. B.

Contents.

	PAGE
University Degrees for Dental Students	489–490
Guildhall Library	490
The Modern use of the Curette: Clinical lecture by Peter Horrocks, M.D.	491–498
Guy's Hospital Physical Society	498
From the Gazette's Special Pathologist	498
Passim	499–501
An Unusual Incident	501
Ophthalmic Notes in Medical Practice	502–504
Pass List	505
Obituary: Dr. Henry Oldham	505
Washbourn Memorial Fund: 4th List	505
Contributions	506
Sport: Rugby Football—Guy's A. v. St. Thomas's A.; Guy's 3rd XV. v. London Hospital 3rd XV.; Guy's 3rd XV. v. Old Charltonians A; Guy's 3rd XV. v. Dulwich College 2nd XV.; Guy's 3rd XV. v. London Hospital 3rd XV. Association Football—Guy's v. Beckenham. Guy's 2nd XI. v. South Norwood—Surrey Junior Cup—Second Round. Guy's Hospital Lawn Tennis Club	506–508
Papers by Guy's Men	508

Calendar of Coming Events.

Dec., 1902.

Sat. 6.—1 p.m., Clinical lecture by Dr. Pitt.
Messrs. Symonds and Steward's take-in; Drs., P. A. Peall and B. W. Lacey; Cl., L. H. Moiser.
G.H.R.F.C., I., Northampton, away.
II., Boro' Road College, home.
III., Ealing "A," away.
G.H.A.F.C., I., Cheshunt, away.
II., Cheshunt II., home.

Mon. 8.—1.15 p.m., Clinical lecture by Mr. Fagge.
January Appointment List closed.
Exam. for Camb. 1st, 2nd and 3rd M.B. begin.

Tues. 9.—12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 10.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.
G.H.R.F.C., I., Royal Engineers, away.
G.H.A.F.C., I., Wellingborough Grammar School, away.

Thur. 11.—Messrs. Lucas and Lane's take-in; Drs., C. D. Pye-Smith and P. P. Cole; Cl., D. H. Trail.

Fri. 12.—4 p.m., Meeting of the Dental Society.

Sat. 12.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., London Scottish, away.
III., Blackheath School, away.
IV., Streatham "B," away.
G.H.A.F.C., I., Tunbridge Wells, away.
II., Central Technical College, home.

Tues. 16.—12 noon, Mr. Rowell's Demonstration on Anæsthetics.

Wed. 17.—1.30 p.m., Clinical lecture by Mr. Golding-Bird.

Thur. 18.—Lectures cease.
Messrs. Golding-Bird and Dunn's take-in; Drs., H. O. M. Beadnell and R. St. G. Seagrove; Cl., A. H. E. Wall.

Sat. 20.—G.H.R.F.C., II., Polytechnic, home.
G.H.A.F.C., I., South Eastern College, home.
II., Parthians, away.

Guy's Hospital Gazette.

DECEMBER 6, 1902.

University Degrees for Dental Students.

Dental education, no less than elementary and secondary education, has lately engaged the minds of many interested in the future well-being of the community. The University of London, as recently reconstituted, nominated a few members to act as a Board of Studies in Dentistry, presumably with the object of discussing and reporting upon the desirability of incorporating a degree in dental surgery amongst the examinations of the University.

There are many aspects of the question, and it would be well at this stage to put before our readers some of the opinions that are held upon this important subject.

A certain section of the dental profession appears satisfied with the diplomas or licences to practise dentistry granted by the Royal Colleges of Surgeons of England, of Scotland, and of Ireland, as well as of the Faculty of Physicians and Surgeons of Glasgow. They maintain that all the requirements necessary for making a competent practitioner and good operator are provided for in the curricula for such licences, and in the various examinations.

They deprecate any multiplication of diplomas or new degrees, advocating the one-portal system, as amongst solicitors. The medical profession is instanced by them as having caused much confusion in the public mind by its numerous qualifications and degrees, each differing from the other in standard of examination. The advocates of such views advise students to take degrees in medicine, science or arts, if they wish, but consider that the dental diploma covers all

that is actually necessary for the practice of dentistry.

A second section of the profession desires a higher qualification. They do not seek a higher standard of knowledge of general surgery or medicine than the L.D.S. demands, but are anxious to obtain another grade of practitioners —men of proved superior operative and mechanical skill.

Such a grade of dental practitioners could be obtained if the various Colleges of Surgeons were to grant honours in the practical part of their examinations for a dental licence; or other examinations could be instituted by these corporations.

A third and smaller class of dental surgeons aim at making it a *sine qua non* for all aspirants to a dental qualification to pass in the first instance an examination entitling them to practise medicine and surgery.

Having briefly sketched some of the more divergent opinions upon the question of additional qualifications for dental surgeons, we not unnaturally inquire upon what lines the University of London is likely to proceed, supposing that they consider it advisable to grant a degree in dentistry.

In the first place it must not fall short of the high standard of excellence required in allother examinations for degrees in its faculty.

That standard would, in our opinion, entail a three years' Dental Hospital course, instead of two years as now required by the Colleges of Surgeons; and that of itself would enable the student to acquire greater operative skill, and a deeper knowledge of such subjects as bacteriology, histology, and pathology.

Some members of the profession say that the University should not attempt in any way to compete with the Colleges that grant dental diplomas. The University should give dental degrees to their *medical alumni* only, thereby not only bringing dentistry into line with other specialities of medicine—ophthalmology, otology, and gynæcology—but also by creating a special degree, necessitated by the highly technical skill demanded in the practice of dentistry.

Others of the profession think that the full medical curriculum for the degree of M.B. Lond. involves the sacrifice of some of the student's time upon subjects which may never come under his province as a dental practitioner. They regard dentistry purely as a branch of surgery, and say the time of the dental student can be better utilized than by studying the theory and practice of medicine. They advocate the study of medicine being pursued only as far as the intermediate examination for the M.B., whilst the surgical studies and examination should be identical with that for the B.S. Lond.

After carefully reviewing the matter we are inclined to regard it as desirable for the dental student, who aspires to be a teacher or leader in his department of surgery, to have an opportunity of showing that he is a man possessed of more than ordinary skill and learning. We, therefore, hope that the University of London, and the older Universities of Oxford and Cambridge, will see their way to granting a degree in dentistry, but we do not venture to say which scheme would turn out the men best equipped for practice. We feel sure no University in the United Kingdom is more capable of dealing with the question in a thoroughly comprehensive manner than the University of London.

We shall follow with considerable interest the outcome of this subject, and in taking leave of it for the present we can confidently say that there is no general desire amongst the dental profession of this country to be styled "Doctors of Dental Surgery." We believe the degree of Bachelor or Master of Dental Surgery would be far more highly prized by the majority of qualified dentists.

Guildhall Library.

With a view to make the existence and usefulness of the Guildhall Library and Museum still better known and appreciated, the Library Committee of the Corporation of London have arranged for a Lecture to be delivered in the Library by the Librarian, Mr. Charles Welch, F.S.A., on Thursday, the 11th December, at 6.30 p.m. The Lecture is to be illustrated with limelight views and will be entitled "The Guildhall Library and Museum, their history and treasures." Its main object will be to show what rich provision exists in the Library for the wants of students of all classes and men and women of every calling and profession. Admission will be free, and tickets may be obtained on application at the Library.

The Modern Use of the Curette.

CLINICAL LECTURE BY PETER HORROCKS, M.D.

November 3rd, 1902.

Gentlemen,—The word curette, as you know, is a French word which means *a scraper*, and I daresay if one could go far enough back one would find it used a long time ago. But Récamier, in France, introduced it afresh close upon sixty years ago, and he published a few cases illustrating the use of this instrument for scraping the womb. He met with such a storm of opposition from all the best men of his time that practically nobody else tried it. Since then it has been introduced again and again by different gynæcologists, who have made little alterations in Récamier's curette, little improvements, but every one of them had to give it up because the best men of the time condemned it utterly. They condemned it very properly too, simply because it was used before aseptic days. Until Pasteur and Lister had founded modern aseptic surgery, it was a dangerous weapon to use; its employment being followed, as a rule, by some form of pyrexia due to some inflammation. It introduced on its tip, in all probability, streptococci or other microbes, and the result was the inoculation of the patient with the germs, when they were present, and a condition was set up which proved worse than that for which the curette was being employed. In fact, the inoculation frequently resulted in symptoms of endometritis, salpingitis, pyosalpinx, pelvic peritonitis, general peritonitis, pyæmia, and even death itself. These unfortunate consequences were not the fault of the curette, or of the doctor, or of the patient, but were merely owing to the lack of the knowledge of asepsis. However, after Pasteur and Lister had founded modern surgery, the curette came into use again, and it is now often used for a variety of purposes, and practically without any danger.

All kinds of curettes have been invented, but they can be divided into "blunt" and "sharp," and either of these may be "simple" or what is called the "flushing" curette, an arrangement by which fluid can be injected through the instrument into the part being scraped, and the scrapings washed away as fast as they are scraped off the surface. For myself, I like for practical general use a blunt curette, and of this kind (shown). This is the sort of curette that I nearly always use. It is light and is really composed of a piece of thick wire, bent, as far as the handle is concerned, into a kind of loop, or fenestra, and that loop, about three inches long, not only makes the instrument light, but enables you to hold it steadily, so that you have the scraping edge held against the uterine mucous membrane which is to be scraped. The extreme width of the loop is three-quarters of an inch. This looped wire is joined at the point, and passes on as a single wire, the stem gradually tapering off and getting thinner towards the scraping edge at the end. This stem measures about six and a half inches, and terminates in a small loop. The extreme width of this terminal loop is not more than about a quarter of an inch, which enables you to pass it through the canal of the cervix without any or very little artificial dilatation by means of dilators. This loop is bent at an angle with the stem, so that you may apply the scraping edge of the curette closely against the mucous membrane. This particular curette (shown) is rather shorter than that generally used. This (shown) is a blunt one and we have used it a good many times, and though the handle is apparently of solid metal, it is not really so, but is hollow inside. It is also a very good instrument. But this made of wire is a cheaper instrument (shown) and lighter, and I think it is an excellent one. Most blunt curettes are called Thomas's. The blunt curette is what I should recommend any practitioner to get for himself. You do not want sharp curettes, and I do not think you want a scoop or sharp spoon. This (shown) is really for scooping out cancer. The ordinary blunt curette is about ten and a half inches long altogether.

Then there are various modifications in the construction of these instruments. Here is one (shown) that has got a blunt curette at one end and a sharp one at the other; it is two in one but is not quite so easy to use. Here is a flushing curette (shown). It has got a tube running through it, by means of which fluid can be injected on to the curetted surface

through this little orifice, thus washing scrapings away. You very seldom see this curette used in Guy's, simply because it has no advantages over curetting with the ordinary simple curette. It is not as if by not using this instrument we get sepsis. At Guy's we have not had a case of sepsis from curetting for years, and yet we have generally two or three cases in the wards every week that are curetted. It shows that the flushing process is not necessary, and so we do not use it. Some authorities speak very highly of the flushing curette, and I think therefore that you ought to know there is such a thing, and know how to describe it if need be. But, nevertheless, when you get into practice you will find that this simple wire one is all that you require.

Now, if you had a case suitable for curetting how would you perform the operation? Many people recommend the lithotomy position, but we always take the left lateral position. I do not mean Sims' position. The left lateral position differs from Sims' position in this—that the patient lies on her left side with the right knee on the left knee, whereas in Sims' position the right knee is pulled in front of the left knee so that both knees touch the table and the patient's left arm is kept behind her and she turns her body towards the table. Sims was very strong on the point and maintained that if you had the patient in this position, the uterus fell away towards the abominal wall, and that gave you more room. But you do not require that in curettage.

Of course, everything is made aseptic, and I suppose you know how to manage that. A Sims' speculum is passed into the vagina, and then you get an assistant to help you. The assistant is very apt to try to do too much. I always ask him to hold the speculum lightly, not stiffly and rigidly, but lightly and yet firmly, and with his left hand to draw the right gluteal region up so as to enable the operator to see the cervix uteri. What the assistant is apt to do is to let go with one hand or the other whilst he reaches for something, with the result that the operator is unable to see properly. You then swab out the vagina and the surface of the cervix, and with the uterine tenaculum you seize the anterior lip of the cervix and draw the uterus down sufficiently to bring the os within nice view, but no further. Then you take a uterine sound and pass it into the uterus. You find in that way its position and length, and whether there is any stenosis at the external or internal os, or in the cervical canal, also whether there is a real or only a potential cavity in the uterus. As a rule an instrument like this (shown) with no wider a loop than that will pass into the uterus without any artificial dilatation. But if it is necessary to dilate the uterus in order to pass in the curette, we use Hegar's dilators up to No. 9. What does No. 9 mean? It means a definite measurement, namely, a dilator nine millimetres in diameter.

A No 9 dilator is quite enough for curetting purposes if it is found necessary to dilate at all. If you are going to scrape out the whole interior surface of the uterus with the curette—the common operation in curetting—then you begin at the posterior surface and scrape downwards, using not too much force. You do not want to tear the uterine wall. The amount of force to employ has to be learned by experience. The vegetations on the surface are unhealthy diseased tissues and come away easily. When you scrape such a surface sometimes you find great lumps of mucous membrane come away. If with the force that ought to be used you were to scrape a perfectly healthy mucous membrane, you would not scrape anything off, or at all events very little. Well, then you scrape as far as you can go over the whole posterior surface, starting each time at the top and ending at the bottom. Next you turn the scraping edge forwards and scrape the anterior surface, and afterwards the sides in the same way from top to bottom. Some people say that the sides near to the orifice of the Fallopian tubes are most important to scrape as the disease is most marked there, also some say that if you do not use the flushing curette you ought to thoroughly wash the uterus out after the curettage. We never do it. Perhaps we might in certain cases, but in ordinary curetting we do not wash the uterus. We draw out with the curette most of the scrapings, and then we pass into the uterus a Playfair's probe

wrapped in cotton wool, and wipe out any little bits that may be left. We then take another probe with cotton wool dipped in whatever solution we want to use, tincture of iodide if you want a mild antiseptic, or pure carbolic acid, which is stronger, or iodised phenol which is still stronger (we have not used strong nitric acid for years, but if it be required it is applied by means of a glass rod), and pass the probe into the uterus, turning it round so as to bring the antiseptic on to the scraped walls, any little bit of débris is thus rendered perfectly aseptic by this antiseptic solution. So that it is not necessary to wash out the uterus. I think it is a little dangerous to do so unless you have a good channel, that is, free exit from the uterus. It does not do to inject fluid into an organ like the uterus unless you have free exit, it might set up peritonitis by being forced through the Fallopian tubes.

I have described to you the instrument and the method of using it. Now we come to the important consideration. When should this instrument be used? I am going to put you down a list of things for which the curette should be used and shall put them down in the order of merit, taking the word *merit* to mean *frequency*.

(1.) First of all, the curette is used for "menorrhagia," or profuse menstruation. A patient comes very frequently complaining of profuse menstruation. Perhaps her menses began at the age of fourteen or fifteen and were not profuse at first, but now they are very profuse. She loses a good deal. You find no cause for it in particular, but you strongly suspect she has endometritis. If you find with the speculum a little erosion at the os externum you may be sure the case is one of endometritis. You give her drugs, but the disease goes on, and is a case when the curetting is justifiable. Menorrhagia is one of the commonest things for which curetting is done when the menorrhagia is due to endometritis. But it might be due to other things for which curetting is not desirable. Supposing a lady, nearly fifty years of age, consults you with profuse menstruation, and you do not find any cause in particular for it, it might be due to the onset of climacteric changes. In that case it will probably be best only to give bromides. But if you find endometritis, as, for instance, in people who have been living in India or some hot climate, curetting generally does a great deal of good. Or the menorrhagia may be due to subin solution; a lady has miscarried and after that she loses a great deal at each period. The uterus is found to be simply big and bulky, involution being incomplete. Curetting does great good in those cases also.

(2.) *Metrorrhagia* or hæmorrhage in between the periods. Curetting is done for it especially when it is due to retained products of conception. A woman has miscarried and she keeps losing, and there is probably something left behind. She aborts in the early period and the chorionic villi or the placenta do not come off the mucous membrane. It is like an unripe plum in which the fruit does not come off the stone easily. Little pieces of chorion or placenta are left behind and cause hæmorrhage. Curetting cures this condition.

(3.) *Fibroids.*—Fibroid tumours of the uterus are very common and they nearly always produce menorrhagia. Therefore I might have put *fibroids* under the heading of No. 1. Only in fibroids there is a tumour and the exact cause of the menorrhagia is disputed. In all cases the uterus is enlarged and the menstruating area is increased. This may be the whole explanation, but according to some writers there is always more or less endometritis present in cases of fibroids. Now fibroids as a rule do not kill the patient if they are left alone. After the change of life they begin to atrophy and in some cases seem even to disappear. At all events unless there is a good reason for operating, you can often lessen the menorrhagia by curetting and so relieve the most urgent symptom and enable your patient to reach the climacteric when the beneficent atrophic changes begin.

(4.) For *diagnostic* purposes—a piece being removed for microscopical examination. We have a patient in my ward now, and she was losing blood, not only at the periods, but also in between. She was also losing flesh and complained of pain, and the question was, Is it cancer of the body of the uterus, for the cervix was healthy? Well, to

remove the uterus on the hypothesis that it was cancer would have been rather heroic. Nowadays you can fish out with your curette a small piece from the interior of the uterus and submit that to examination and find out whether it is cancer or not. If it is cancer then you should recommend the patient to have hysterectomy done. In the case of the patient to whom I have just referred, she was put under an anæsthetic and we fished out a piece for microscopical purposes, but even to the naked eye it was obviously cancer, so I proceeded at once to remove the uterus. When you do curetting for diagnostic purposes, and with little pressure you find that the instrument brings away easily biggish lumps, generally whitish and soft, then that is cancer in all probability. When you are not in doubt you can proceed to do hysterectomy. If, after scraping a piece out, you are not quite sure what it is, you can submit it for microscopical examination to one of the excellent institutions now in existence for the purpose, and they will give you a report. You might happen to scrape by the side of the area affected by cancer, and get a report that it was healthy, because you have not scraped the diseased part. So that you have to be very careful to scrape the part that is diseased. If you get a report in any case that it is not cancer and the patient gets worse, then I should advise you to commence an operation for hysterectomy by dissecting the bladder off the front of the uterus, then slitting up the front of the uterus, which enables you to feel with your finger if there is cancer inside; if there is not cancer, sew it up again, and if there is cancer remove the uterus.

Those four exhaust nearly all conditions for which you commonly do curetting, but there are some more to be put down. One of them is—

(5.) *Dysmenorrhœa.*—The patient does not complain of great pain during the periods, and often you will find on enquiry that she passes clots. You may try drugs, but let me give you a warning here—do not try opium. Opium will relieve the patient's pain, but you will have to keep on giving it every month, and after a time you will have to give it in between the periods, and eventually her life will not be worth living, the patient will become a nuisance to everybody and her state will be worse than it was with the original dysmenorrhœa. But where you find that the pain is due to the formation of clots in the uterus, if you cure the clotting you cure the dysmenorrhœa. You curette the uterus, swab it out with some antiseptic, and perhaps thereby set up a healthy condition of the mucous membrane, and the periods subsequently are without clots and therefore without pain.

(6.) *Sterility.*—It is a curious thing that curetting will produce sterility and sometimes cure sterility. I do not think it is a good illustration of the homœphathic principle of *similia similibus curantur*, because when curetting produces sterility it is because the instrument is used too freely; it has scraped away all the mucous membrane and all the formative elements. There are always plenty of formative cells to form a new mucous membrane after a curetting properly performed. You find in books pictures of the endometrium so many weeks or months after a good curetting, and if the curetting has been done properly the epithelial covering is perfect. But if a sharp curette has been used it is quite a different matter. I have a patient now who was curetted by somebody, and she is very angry indeed because she has only a mere "show" every month and because she remains sterile. The ovaries are right enough and form an ovum every month, but when this ovum comes down to the uterus there is no mucous membrane, or scarcely any, and she has a mere show. Her mucous membrane was nearly all scraped away. She will never have a child, because the endometrium that should form the human nest is spoiled. You do not want to spoil it by curetting it too much. A patient comes and says she has never had any children and has been married several years. In such a case, supposing no cause for sterility is found, if a healthy condition of mucous membrane can be set up, there is no reason why she should not have a child, and as a fact this little operation is not infrequently successful. So that curetting will sometimes cure sterility.

(7.) *Offensive menses.*—A patient complains of the menses being so offensive that she is a nuisance to herself; she does not go out at all.

during menstruation, because she is such a nuisance to herself and everybody else. I have a patient in now, who told me that her menses were so offensive that she could not bear it any longer. We took her into Queen ward and the diapers had a most offensive odour. What is that due to? There is no doubt that it is due to an unhealthy condition. I do not pretend to tell you what the microbe is, though there may be one that causes the menses to be offensive by setting up some form of decomposition. This lady has got no cancer and no sloughing fibroid or retained dead products. She is healthy enough in the vagina and cervix, but she must, we think, have something in the uterus. We shall curette and swab out the uterus to set up a healthy condition and make the menses not so offensive as to cause her to complain about them.

(8.) *Puerperal fever.*—I use the word *fever* because I want to include sapræmia and septicæmia. Puerperal fever simply means blood poisoning in a puerperal condition. Puerperal sapræmia is due to something decomposing in the uterus and the patient is poisoned. Puerperal septicæmia is due to micro-organisms in the blood which multiply and result in blood-poisoning. I remember reading a paper at the Hunterian Society on Puerperal Fever (1890), and some of those present objected to curetting in such cases. They thought that the scraping out of the uterus was making a highway straight into the blood for any germs that might be inside the uterus. But it is a well known fact that after child-birth, where the uterus is fixed by perimetritis or parametritis, the patient might be ill from three weeks to three months according to the time which it took the inflammatory product to resolve or be discharged, but she gets well as a rule. Whereas if a patient were ill with rigor and fever, and there were no perimetritis or parametritis, and it were true septicæmia and not sapræmia, the result was generally fatal. By scraping the uterus with the curette in such a patient you often did set up perimetritis or parametritis, and the uterus became fixed soon afterwards. The curette seemed to start it. The patient was ill for a considerable time, possibly with much fever, but recovered eventually. Since then curetting for puerperal septicæmia has been done frequently, but even yet a good many hesitate to do it. I should not hesitate myself to do it in cases that I thought were really bad cases of puerperal septicæmia and likely to die. Some people now recommend curetting in cases of pelvic inflammation but I do not think it should be used in such cases.

(9.) *To induce miscarriage.* — Criminal abortionists use the curette. Curetting is a certain method of bringing on miscarriage, and by miscarriage I mean anything before and up to the seventh month. But it is generally done early on. A woman having run a risk of becoming pregnant misses a period. She is in fear that it is pregnancy and she goes to a man who for a consideration will bring it away. At this early time the thing is a mere bud in the uterus and the curette will bring it away far more certainly than a sound. If you pass an ordinary uterine sound into the uterus—and you might pass it even more than once—you might possibly not disturb the ovum at all, and there might be no bleeding or very little and the patient might go on to her full time if not interfered with further. Passing a uterine sound to bring on miscarriage does not act always, especially when you want it to act. Supposing it were a legitimate thing and you wanted it to act, it might not act at all, and, *vice versâ*, if you don't want it to act it generally does.

I once passed a sound into the uterus of a pregnant woman under the impression that it was a fibroid tumour. She was a married woman who came to the Out-patient room. The following week a friend of hers came to tell me that the patient had miscarried quite comfortably two days after I had passed the instrument. The woman was about five months gone. She and her husband were very pleased as they had got a lot of children and did not want any more, and they blessed me. But it was quite a mistake and taught me a lesson. If you pass a sound into a patient's uterus, say two weeks after conception, the ovum is a mere bud on the uterine mucous membrane, and probably the sound would not touch it. But the curette, even though you do not scrape where the bud is

growing, but some other part, sets up hæmorrhage and uterine action which expels the bud, and of course if you curette the bud you spoil the ovum. Curetting, therefore, is a certain method of bringing on miscarriage. Supposing you had a case where it was legitimate to bring on miscarriage in a very early stage of pregnancy, it is one of the best methods we have. When done legitimately it can be done with scarcely any risk, because you are not doing it in secret. Those criminal abortionists say to a patient, "I cannot run any risk; you must bring your money and put it down, I will start the miscarriage and you must then go home." He scrapes and sets her bleeding, and flooding takes place, and she runs grave risk from hæmorrhage. He does not do it under aseptic conditions and she runs grave risk from septicæmia. He often does it clumsily and she runs grave risk from injury. Whereas, if you do it legitimately, in the open, you make the patient perfectly aseptic and you have her under observation. If curetting brings on too much hæmorrhage you can give an anæsthetic and quickly clear out the whole of the contents of the uterus, when the bleeding is arrested. The whole operation is done aseptically and so the risk of septicæmia is exceedingly slight, and of course if you do it *secundum artem* you will do her no injury. So that although criminal abortionists use the curette, I am telling you about this instrument which can be used legitimately and with very great efficiency. Those are all the conditions for which the curette may be used to the interior of the body of the uterus (for use to cervical canal *vide* addendum), and I could give you cases illustrating every one of them, but I see the time is going too fast for that. We have got a case in the ward now where we curetted for menorrhagia. I fished out a piece for microscopical examination and found it was cancer, and therefore removed the whole of the uterus, we did it abdominally because she had a small vagina, and it was impossible to remove it *per vaginam*. But you might be able to do some cases *per vaginam*. I must refrain from giving you illustrations in every case that I have mentioned, but those of you who are interested in the subject can come on Mondays, Tuesdays, Thursdays, and Fridays, and see curetting done in Queen ward. I will assume that I have told you of a number of cases where curetting has been successful.

Now I will tell you that there are cases which are not benefited by curetting, or, if they are it is only for a time. In a case like that I think it is quite legitimate to do it a second time. Perhaps at first you did not do it sufficiently or efficiently. Supposing she has a period lasting ten days, with pain, I think you may do it a second time and even a third time, each time applying a stronger antiseptic. But supposing you do it two or three times and the patient does not get better, it is no use going on curetting, you must do something else which I will tell you of presently. The repetition of curetting must be taken on its merits. You must consider the matter and use as wise a judgment as you can. Sometimes the patient is very angry with her doctor because after curetting she does not get well, and therefore I should advise you not to promise that you will cure a patient who comes to you. "Well," some patients say, "If I have an operation done, will you guarantee that it will cure me?" Say, "No; I think it will do you good and will probably cure your complaint. It does good in most cases, but there are a few cases in which it does not, and if it does not do you any good you must not blame me." If you say you will cure the patient, and it is one of those cases in which curetting does not prove successful, you get yourself into hot water. Supposing you get a case where, after curetting once, twice, or three times the patient is no better, what is the best thing to do? In such a case recommend the patient to be explored, that is, to have the uterine cavity digitally examined. We had an excellent illustration of that about the end of July last. The patient was 40 years of age and single, and she had severe hæmorrhage at her monthly periods. Her doctor sent her to me privately, and on examination, in the first place, I found that the uterus was nulliparous and very little enlarged. I could not feel any fibroid and the slight enlargement was uniform, but I found that the uterus was rather in a retroverted position, which was remedied by a suitable lever pessary. She was working in an office

and one day she was taken with a flooding and had to be conveyed home. Her doctor wrote and said something ought to be done. I told him that we could curette her at Guy's, and accordingly she was curetted in Queen ward. She afterwards went out, but instead of being better she became worse than ever and had floodings again. She came here in August for further treatment. The plan I adopted is one which I have followed in many similar cases. The bladder was dissected off the front of the uterus without opening the peritoneum and then the anterior surface of the uterus was slit up, beginning at the external os and cutting through the whole of the cervix to a little beyond the internal os. This enabled me to feel inside the uterine cavity where I found a fibroid polypus nearly as big as a walnut hanging from the fundus by a short pedicle. The latter was cut through, the polypus removed, the uterus sewn up again and iodoform gauze wrung out in formalin (1 in 750) was packed in the vagina. She recovered quickly and soon went home. I have just seen this same woman last week, and she has had one period since the operation which lasted only five days, and there was just the average amount and she is again following her employment. I think we have cured that patient. That is only one of many similar cases that I could tell you of. There was another patient in Bright ward some years ago, who had been curetted six times. I was the one to do the sixth curetting. Previously she had had fearful hæmorrhage. I advised exploration, and accordingly opened the uterus along the front in the manner already described. I found, however, no polypi, but the whole of the uterus was filled with intra-mural fibroid tumours varying from the size of a pea to the size of a walnut. I removed the whole of the uterus by vaginal hysterectomy. She was married but had had no children. These fibroid tumours had, no doubt, prevented conception. She has been in excellent health ever since. Curetting was no good at all for a patient like that. It was absolutely necessary to do something more radical. If, therefore, a case is not cured by curetting once or twice repeated it is best to explore.

I must tell you a few of the dangers of curetting. The dangers of curetting are—(1) *hæmorrhage*. If you curette and open a small arteriole of a cancer, you might have very profuse hæmorrhage. If you are curetting in the case of a woman who is pregnant, and you do not know it, you may have very profuse hæmorrhage. If you curette in a case where you wish to bring on miscarriage you may have extremely profuse hæmorrhage. In cases of cancer you must be prepared either to plug the uterus and vagina, or to go on with the operation and remove the uterus. Supposing it were a case of pregnancy, and the patient was losing and likely to go on losing, you would not dare to leave such a case without treatment. If you plug the vagina the hæmorrhage may still be going on just the same. In such a case the best plan is to empty the uterus forthwith. If you are not prepared with the necessary instruments, then plug the vagina efficiently and completely with sterilized gauze and put on a T bandage and get the instruments required as soon as you can. The patient is then anæsthetized and the plug removed, the uterus dilated with Hegar's dilators up to No. 19 and the ovum removed with the finger.

(2) *Sepsis*.—We have not had for years a case of pyrexia following curetting, but we have here, of course, everything that a hospital can give you, whereas in a private house you do not always get perfect conditions of this kind, and in spite of all you can do you might perhaps get some sepsis. So that you do sometimes get fever, salpingitis, peritonitis, perimetritis, septicæmia, and even death. But that ought not to occur in these cases of curetting. Sometimes the sepsis is not due to the doctor, it might be due to something in the uterus disturbed by the curette.

(3.) *Perforation*.—I do not think it is possible to avoid perforating the uterus sometimes. I have only perforated it with the curette once, and I do not think it was my fault, it was the fault of the uterus, which was just like blotting paper. I passed a sound in and also a curette, and the curette went on and on and nearly disappeared, and I found it under the abdominal wall. I took it out again and did not apply

anything within the uterus, and the patient never had a bad symptom. But I was in a state of considerable alarm for a day or two. The curette may pass right through a soft cancer. They had a patient in one of the hospitals in London some little time ago illustrating that fact, and this patient died, and when the post-mortem was made you could see it was impossible to pass any instrument without running a great risk of going through the uterine wall. So that it is not always the fault of the operator. Nevertheless, he may use too much force and push the curette through comparatively healthy tissue, in which case he is of course to blame.

(4.) *Sterility.*—If not merely the diseased mucous membrane but also the healthy tissue be scraped away—and this is most likely when a sharp curette is used—there may be an insufficiency of formative cells left behind to reconstruct the endometrium or at all events it may be reconstructed on little islets only and not as a continuous membrane. Hence the endometrium as the nest for the human ovum is spoiled and the woman is incapable of bearing a child.

(5.) *Scanty menstruation.*—This is caused by the same thing, namely, over scraping. I know a case now of a lady but little over thirty years of age whose periods used to last five or six days, with an average loss of blood, who now only has a mere stain on the diaper for a few hours once a month.

Addendum.—In cases of cervical leucorrhœa producing the common discharge, called by women "the whites," it is found to be due to chronic cervical catarrh. The mucous membrane lining the cervical canal is, as you know, not only peculiar in being arranged in folds forming the so-called arbor vitæ, but it is also studded with a large number of mucous glands or follicles. Ordinary vaginal syringing does not touch the disease, but only washes away the mucoid secretion. The application of caustics within the cervical canal often does good and sometimes cures if sufficiently repeated. But one of the most efficacious methods of curing this complaint is to thoroughly curette the cervical canal, and in this case a sharp curette is required and more force is needed to get rid of the inflammatory tissue. Then caustic is applied, such as pure carbolic acid, and as a rule there is an excellent result.

Guy's Hospital Physical Society.

A Meeting of the Society was held in the Library, Nov. 19th, Mr. Blake-Odgers in the chair.

Mr. Parker showed an enormously enlarged heart from a case that was thought to be arterio-sclerosis. The kidneys were granular, and there was meningeal hæmorrhages all over the base of the brain.

Mr. Blake-Odgers showed some intestinal sand which was passed by a patient suffering from mucous colitis.

Mr. Keates showed a specimen of thrombosis of the splenic vein. The patient was admitted with a ruptured tubal gestation. An operation was performed at once, and the abdomen found to be full of blood. Intravenous infusion of normal saline solution was carried out, and the abdominal cavity was left full of the same fluid. She rallied well after the operation, but failed rather rapidly and died twenty-four hours after the operation. The only condition found post-mortem was the thrombosis of the splenic vein. Mr. Keates discussed the possible causes of thrombosis.

Mr. Brydone contributed a series of cases of thrombosis following operation that had come under his notice.

Mr. Keates next showed a large fibro-cystic tumour of the uterus.

Mr. Spriggs showed a specimen of lipæmia from a case of diabetes.

Mr. Atkins showed a carcinoma of the pyloric extremity of the stomach that had caused no obstruction or symptoms referable to the stomach. The patient at death was found to have infective endocarditis, and three infarcts in the spleen.

Mr. Brydone showed some interesting specimens of diseased Fallopian tubes. The first was a case of unilateral large tuberculous salpingitis, free from adhesions. The second, one of double pyosalpinx, not tuberculous. In the former case the tube was enormously enlarged, and Mr. Brydone referred to the difficulty that existed at times in such cases in diagnosing the condition from ovarian cysts.

Mr. Cutler showed some specimens from a case of cancer of pancreas with secondary deposits in the brain. The patient was admitted with hemiplegia, but had no abdominal symptoms.

From the Gazette's Special Pathologist.

E. A. S., Tunbridge Wells.—This specimen consists of dense fibrous tissue like fascia with lines of small inflammatory cells between the bundles. There are no nerve fibres in it. PATHOLOGIST.

Passim.

To-night the first Smoker will take place at 8 p.m. in the Dining Hall, under the presidency of R. Clement Lucas, Esq., Senior Surgeon, and we hope will be fully attended. Tickets (2/–) for the Dinner—the only dinner—may be obtained at the bar, and for the Smoker (1/–) from any of the Residents, or from the caterer. It is to be hoped that a good company will turn up to greet our popular president. Mr. Lucas will be the guest of the Residents at the House Dinner before the Smoker, at which seats should be engaged without delay.

The LVII. Volume of the "Guy s Hospital Reports" lies before us, and we have nothing but congratulation to offer the Editors. It may be of service also to point out that the terms of subscription have been altered. The former arrangement, by which the Clubs' Union member was presented with a volume of the Reports, has been varied. It was found to be a heavy drain on the Clubs' Union resources, and it was found that as a copy was printed for each member that a quantity greatly in excess of the applications for them was brought into existence, wherefore the arrangement has been varied. Members of the Union can obtain this volume from the Librarian, price 6/–, including postage, and the public generally can obtain it for 10/6.

Another link with the past has been snapped by the decease of Henry Oldham, Obstetric Physician and Lecturer from 1849 to 1868. Born in the year of Waterloo, qualified before the Queen's accession, and retired before Dr. Galabin's arrival at Guy's, he may well be considered one of a remote epoch, and yet John Birkett was almost a contemporary of his, and served his full time on the Guy's Staff, and is yet with us. He was working with and under Bright, Astley Cooper, Key, Cock, and a whole host of intellectual giants, and he was a physician from the resignation of King Harrison through the most glorious epoch of Guy's annals, perhaps, 1850 to 1870, when the Hospital was in full swing, abounding in funds, in rapid advances in surgery and pathology, and the whole Hospital was in a state of unparalleled intellectual advance, and the depression had not yet arrived.

The Heath Prize of £200 for the best Essay on so vexed and important a surgical question as the enlarged prostate, its anatomy, and so forth, is, to our mind, one of the most admirable attempts of endowing research that we are familiar with. It must be confessed that chairs of surgery and titled lectureships are often but highly-sounding and inefficient offices, and that genius and genuine research is rarely to be found in the well-equipped and fashionable laboratory, and therefore we feel that if the Heath Prize is competed for by such men as are qualified to write, an obscure point in surgery will be satisfactorily elucidated. In fact, we think the prize will attract good men, and the choice of the subject admirable. May it come where it should, to one of our many rising junior men; we commend it to their notice as a worthy subject for research. Entrance fee is a Durham Degree.

The Fellowship of the Royal College of Surgeons is an ancient and honourable distinction that is viewed with great respect, and one which always attracts great attention. Many reasons contribute to this. It is the final test of the career of the keen and the slack, of the apparent advertized "failure" or "success," and occurring at the time of their widest fame, naturally attracts the eyes of all to the fierce trial. Among the privileges it confers, is that of being present and hearing the replies of candidates for Membership and Fellowship. A rumour reaches us that certain recently-created Fellows took a mean advantage of their position to listen to their *former colleagues'* replies in a time of unwonted stress and difficulty, and can only say we hope such an ungentlemanly use of their privilege will not be complained of again. It is quite a question whether it is at all fair to expose a candidate to publicity at all in a vivâ voce, though the former practice of ancient Universities may be quoted in support of it.

It was decided at a meeting of the Residents in the Charities' Room, after hearing several opinions, to attempt to get up some theatricals as a Christmas present to the Nursing Staff on the lines of the performance given in 1901. It is, in the main, a matter of money, and we have not the slightest hesitation in asking if any of those who saw or heard the entertainment last year and approved of it will subscribe towards the rather heavy expenses. The work that Christmas Festivities entail on the Residents and Nursing Staff is little realised, and most people prefer to keep the question of cost in the background. But without revealing secrets, and in spite of several generous donations, the Christmas season means an unfair claim on the purses of Sisters and Residents, so that with so good an object in view we feel quite justified in asking that any who are willing to help the Residents in the expenses of the theatricals will let any one of the Committee know, and the sooner the better.

The proposal is to act two pieces, the first serious and the second farcial, and to fill the interval with a concert; to give two performances so as to enable all the nurses to attend, if possible, on Boxing-night and the night after, Friday and Saturday, December 26th and 27th. The members of the Committee are the Residents and Mr. Woodward; the Stage Manager is Mr. Woodward and the Treasury Manager Mr. Brydone, and the Property Manager is not yet appointed.

Contrary to expectation, the First XV. defeated the Old Merchant Taylors fairly easily, and the sporting world rejoiced greatly thereat; but it rather diminishes the glory to find that two positions in the field were filled by men of ancient fame, whose skill is certainly above that of the average player, and that for two reasons. Firstly, that it gives the team a false impression of its strength and prowess, and conceals its defects, and secondly, and most important, it is a most pernicious practice in itself. The powerful Fifteens of the last five years are the direct outcome of the years of toiling in the wilderness and the result of great devotion to and success of the Second and Third XV.'s of former years, from whose ranks the ever-victorious first winning Cup Team was almost entirely recruited. If the places in the First are not filled before the Cup Ties by those who may play in the Cup Ties, we shall not win nor shall we deserve to do so.

The downfall of the once all-conquering St. Thomas's XV. was almost entirely due to slackness and want of interest in the 2nd XV. which prevailed at the end of the sway, the "cracks" fell out and the real barrenness of the land was seen. The matches, except against Cambridge, should be for members of the hospital in their year, and if they cannot play the places should *not* be filled by men out of their year. If men out of their year are anxious to give the hospital the benefit of their skill, let them strengthen the 3rd XV. True we hold strongly that it is quite absurd to restrict the period of play to five years, seeing that the average stay is longer, but as long as the conditions remain unaltered we cannot but condemn the policy of not being prepared for emergencies.

We have always been great admirers of our ancient and illustrious contemporary, the *Lancet* —a paper to whose early indomitable energy and persistence modern science owes a great debt. But we think we have found e'en great Homer nodding, *neque semper arcum tendit Apollo*. There appeared in the correspondence column a query from a country correspondent (and these are usually amusing) as to the treatment of cramp in pregnancy, and we were not disappointed when the next issue gave lightheartedly as a specific remedy to hold a stick of sulphur in each hand, "presumably," says the *Lancet*, "till she goes to sleep." Alas, we had thought that here the *Lancet* shared our amusement. But no, in its most professional and impressive manner our contemporary then discusses the various reasons for the success of the method!

Firstly, the physio-chemical, or science-made-easy-for-children method! "Roll sulphur becomes slightly electrified and becomes partly converted into sulphuretted hydrogen when in contact with warm, possibly moist, skin. This gas might possibly have some

action *upon the circumstances to which the cramp is due*" (delicious sentence this, sonorous and uncommittal), "although the pathology of cramp in pregnancy is not very well understood" (the bow is indeed unbent). But much as the above is food for delightful reflection, for surely the Harness Electropathic Belt was scientific compared with it, it is dwarfed by the humour of the last two paragraphs. "In testing for knee-jerks it is advisable to make the patient hook the fingers together and then try to separate the legs, for in this way the *muscles of the leg remain relaxed.*" It is interesting to ask why runners grip cylinders of cork. Dear, simple sub-editor, it is because it sets all the muscles throughout the body and gives the hands something to grip and cork, because it is light. But a light dawns upon him. Thirdly, the effect may be due to suggestion, and a roll of any other substance might have exactly the same effect!!! Exactly. We suggest a column of "lighter vein."

Some misapprehension exists with regard to the periodicals in the Library. After they have ceased to be current numbers they belong to the purchaser and no longer to the Club, so that it is important to remember that they are not at the disposal of the Club members after that date. Likewise the chessmen are the property of the Chess Club and not of the members of the Clubs' Union.

An Unusual Incident.

There has been lately an inquiry in the Coroner's court which is of more than local interest, and which promised at one time unexpected developments.

The coroner having announced his intention of calling the surgeon in any future inquiry on hearing of the death of an infant, æt. six months, ordered his officer to summon the surgeon to do a post-mortem, and with the anæsthetist to attend and give evidence.

The surgeon's summons *was left at the College* with the house-surgeon's subpœna. The post-mortem at which the surgeon and the anæsthetist were present was done in the usual way, and few if any marks of chloroform poisoning were found. The pathological lesions were chiefly an enlarged thymus and hypertrophied lymph follicles, and a very large cleft palate, the hare lip having healed.

The coroner, after enquiring if the subpœna had been properly served, a point on which he was, we fear, wilfully misinformed, opened the inquiry and announced his intention of adjourning the court for the attendance of the surgeon. The mother's and the anæsthetist's evidence was taken, the jury intimated that as the relatives were quite satisfied, and the house surgeon had testified everything had been done and all proper precautions had been taken, *they* considered it unnecessary to adjourn. However, the inquiry was adjourned, the subpœna as a matter of fact never having reached the surgeon.

Mr. Fripp attended, and the incident was closed without further ado. Before it closed, however, Mr. Fripp took the opportunity of raising the question of holding inquests on such cases as these, pointing out that it was the Guy's custom never to shirk a difficult operation or anæsthetic so long as there was a chance of saving life, and that holding inquiries in such cases did not tend to help the Hospital in their efforts, and were likely to defeat the intention, namely, the welfare of the public.

The Coroner, to whose ability and discrimination the hospital owes much, quite concurred, and stated that it was his intention not to summon the surgeons or necessarily to hold inquests on such cases as strangulated hernia, or as a rule in conditions in which the cause of death was obviously due to other causes than the anæsthetic, but he intimated that in the interest of the public and the hospital he intended to hold a full enquiry into any unforeseen fatalities during operations.

There can be little doubt that the above policy is thoroughly sound and statesmanlike. In the long run the scrupulous care with which the hospital authorities have reported every case in which there was any likelihood of an inquest has certainly shown that we have nothing to fear from investigation, though we believe that as a matter of fact the ordinary hospital post-mortem and demonstration is a more scientific enquiry and quite in itself a sufficiently public one.

The Coroner's view, and we most thoroughly endorse it, is that if there is any question affecting the hospital or any complaint it should be investigated in justice to the hospital and to the survivors, and there can be no doubt that full investigation will save a great deal of error and unpleasantness, and we are entirely at one with the idea he has expressed.

Our regret is that this method involves the risk of publicity in the various newspapers, but we welcome an open enquiry.

It is clear that publicity is obtained by admission of the public, and if the reporters were supplied with an official account it would serve the interests of the public better.

What patient in the wards, after reading in the morning papers sensational details and eye-catching headlines anent deaths under chloroform and the various risks of death, can contemplate calmly his approaching operation

For instance, in Bright, we have heard, the pre-operation nervousness on these occasions has been often quite a painful feature as the direct result of a paragraph in the morning papers.

Ophthalmic Notes in Medical Practice

By W. J. Tyson, M.D., F.R.C.P., F.R.C.S.,
Physician to the Victoria Hospital, Folkestone.

Read before the Members of the Folkestone Medical Society, on October 10th, 1902.

Gentlemen,—It is impossible almost to separate many of the more common eye complaints from ordinary medical practice, and a knowledge how to locate these, or at any rate to apportion their due significance should be possessed by all.

It has always seemed to me that the eye teaching at our Medical Schools has been a mistaken one; too much has been taught, and subjects touched upon which the student when he enters practice will never require, and operations described which he will never perform. The leading points might be given in two or three lectures, and these firmly impressed and illustrated, but to jumble up the important and non-important diseases and complaints of the eye in several lectures, is to court failure, and the result is probably unsatisfactory to the student and the patient alike.

Few men in large general work can keep up all the diseases of eye for want of time or of opportunities of seeing these diseases, but all men should know the more common and important ones, and be able to distinguish, for instance, an iritis from a conjunctivitis, a cataract from a glaucoma, and a headache due to a refractive error, and if these were known more, fixed pupils would be rarer, glaucomatous eyes more frequently saved, and squints and ocular headaches seldom seen and complained of.

The following few remarks will be based upon what I have gathered from among my eye patients which I have generally seen after my general patients at our hospital for the past twenty years, and in my private work, and I will endeavour to make them as much as possible of a clinical and practical character.

I should say that the most common eye trouble which one meets with at the hospital is that of phlyctenular ophthalmia and phlectenular ulcers of the cornea. There are many varieties and degrees of this inflammation in regard to the seat, extent, and course of the disease. Still, there are characteristics common to all forms. The disease is seldom seen in very young children or after twenty years of age. It occurs among the ill-fed and badly-nourished poor; hence the disease is seen much more in hospital than in private practice.

The disease is a constitutional one, rather than local one, hence the slowness of cure. The treatment consists in free home ventilation, warm clothing, good food, and tonic medicine. Photophobia, which is most severe in many cases, will disappear when the pupil of the eye is dilated, and the addition of some form of mercury to the atrophine is beneficial for the ulceration. The constant recurrence of the ulceration points to the constitutional cause playing the most important part.

As a rule when the ulceration has occurred fairly early in life, I have found the subsequent scar disappear, although it may be some two or three years before doing so.

Errors of Refraction.—The above make up a very large proportion of eye work, and there are a good many cases that come to us not directly for the eye, but on examination some refractive error will explain the symptom. Headaches after reading or doing any near work is the most common symptom met with in association with refractive error, and by far the most common condition of the eye in this connection is hypermetropia.

It is a truism, and one that can scarcely be exaggerated, that when any one comes complaining of a headache, always to think that the condition of the eye may possibly account for it. The following points are worth remembering. In testing the vision with glasses, always begin with a plus one, and note down the strongest one which the patient can see the ordinary test type at the ordinary distance, if the case is one of simple hypermetropia, this is the measure of it, but if the case is one of simple myopia, take the weakest concave glass which enables the patient to read the type at the ordinary distance, and this glass will be the proper one.

In dealing with children it is always advisable before ordering spectacles to paralyse the accommodation, for the reason that spasm of the axiliary muscle is often present, and then an artificial myopia is thereby set up. So that these patients see better when you are testing them with minus glasses, whereas they require plus ones. Opticians not unfrequently make this mistake, when neither plus nor minus glasses improve the vision up or to near the proper standard, you almost invariably have to deal with a case of astigmatism. The correction of astigmatism I need not enter into, suffice to say that I think keratoscopy is the best and easiest method of working it out, and that the pupils should be dilated when doing so.

Every now and then one meets with cataracts in young people, or some disease of the vitreous, cheroid, or retina, hence when glasses fail to restore vision, it is necessary to examine the interior of the eye.

When eye headaches are present, they are generally due to hypertrophia or to astigmatism. I hardly remember ever meeting a case of headache due to simple myopia. Myopic astigmatism may give rise to headache, but not simple myopia.

Sometimes even half a dioptric (72m.) left uncorrected will set up a headache.

The danger of uncorrected myopia lies in the resulting damage that takes place at the back of the eye from constant strain, setting up posterior staphyloma.

There is hardly anything more satisfactory in the whole range of medicine than the treatment of headaches by suitable glasses.

As a rule I think it is a mistake freely to correct at first either hypermetropia or myopia. We must not forget "the play" of the eye; in the former the accommodation has had a wide range, and this quality cannot

be quickly reduced; or again, in myopia, the elasticity of eyeball is very considerable, although this must be kept in bounds. Yet in practice I find that a fully corrected myopia is often troublesome to the patient and may lead to his throwing away the spectacles, for his vision is always good at close range, and with ultimate injury to the eyeball.

Again, in dealing with odd eyes, where you have perhaps + 3 D in one eye and + 4 D in the other, if the case is young, there glasses may be ordered, but if this inequality has existed for some years, you will find that in practice glasses mathematically ordered will rarely be found of much value in actual use. I have over and over again seen spectacles ordered on the above plan, but could not be used. We must remember that the eye is not a glass ball, its size is constantly varying, its movements are varied and many, so that it possesses the power to adapt itself to a great extent to many conditions of refraction, and if this power of adaptability has been exercised for some time in connection with any particular refractive error, and you suddenly give a pair of spectacles which may scientifically correct the error, the old habit will often reassert itself and kick, and the glasses cannot be worn. A compromise will have to be effected, as in many other lines of life, before success can be attained.

In connection with hypertropia, I must not forget to mention the condition of squint. It is always internal and is produced by strain of the eye in attempting to do near work. Since the knowledge of the course of the internal strabismus has come about, the operation has become much less frequent. Even when it has existed for some time, atropine and properly fitted and suitable glasses will effect great results.

I have quite convinced myself that if the eye which really squints and remains uncorrected optically for any length of time, the vision greatly deteriorates, and in most cases is never restored fully.

Conjunctivitis, in our neighbourhood, I should say, was not very common; I mean the catarrhal form. If there is any doubt as to its nature think of iritis, and if the patient is under forty years of age put in a little atropine. The most common mistake in the treatment of conjunctivitis is the too frequent and too strong use of astringents; most cases do better with alkalies or boracic acid. I always throw away the usual shade worn in these cases—free ventilation to the eye is beneficial.

Purulent ophthalmia is less frequently seen amongst us since the knowledge of the great importance of aseptic and antiseptic treatment of the eyes, immediately after the birth of the child and for a few days afterwards has become prevalent. When once the disease is fairly started no time must be lost in trivial or proxy treatment. Whenever possible I always recommend admission to the hospital, where regular personal and systematic treatment can be carried out. If this cannot be done, give the child chloroform and apply yourself the specific treatment of nitrate of silver. It is mere waste of time to order the mother or ordinary nurse to apply a lotion, which nine times out of ten never reaches the affected part at all. It is impossible to take too much trouble over these most serious cases.

Tinea tarsi.—Many of these cases come to us from over the Hills, Acryse, Paddleworth, etc.; and one probably due to exposure to our cold easterly or northerly winds. There is one important point to remember in connection with tinea tarsi besides using the well known Ung, Hydrarg. Nit. Mit., that is, its association with hypertropia, and until this is corrected many cases do not recover.

Foreign bodies in the eye are very common in Folkestone. Do not attempt to take the body out or even to look for it until the eye is cocained—this at once removes all pain, and disarms all fears at manipulations; the body can now be quietly removed. If not at the cornea it will almost invariably be found on the inside of the upper eyelid, when this is everted.

Glaucoma.—Of all diseases of the eye this is the one in which most mistakes are made. The acute cases are mistaken for iritis, and the chronic cases for cataract. Remember that an inflamed eye with a dilated pupil usually means glaucoma, a contracted pupil with inflammation usually indicates iritis.

Never put atropine into an eye of a person over forty, without at first estimating the tension of the globe, for if you do you may bring on an acute attack of glaucoma in a sensitive glaucomatous eye.

If you will only always think of the possibility of the presence of glaucoma in an inflamed eye you are not likely to make a mistake.

There is a quiet form of glaucoma, passive in its progress, which is often thought to be cataract. The systematic use of testing the tension of the eyeball, after ophthalmic examination, will remove all diagnostic difficulties.

Never say that a person has a cataract unless you can see a distinct opacity, even by direct focal illumination the lenses of old people have a hazy appearance, and this is apt to mislead one. The direct and indirect methods of ophthalmoscopic examination will remove your doubts.

Pannus.—I have met very little of this trouble in Folkestone; the two common cases are (1) granular lids, and (2) the phlyctenular form coming on after repeated attacks of phlyctenular conjunctivitis and keratitis, the former affects the upper half of the cornea, and the latter the white of it.

Great œdema of the eyelids.—In all these cases give a general anæsthetic, as often a corneal ulcer is present, and any undue pressure on the eyelids may cause rupture of the eyeball.

General diseases affecting the eyes.—When you think that all the following diseases and poisons may, and often do, affect the eyes, viz., syphilis, acquired and inherited, small pox, diphtheria, measles, purpura, septicæmia, lead, alcohol, tobacco, kidney disease, diabetes, leucocythæmia, pernicious anæmia, heart disease, tuberculosis, rheumatism, and gonorrheal rheumatism, gout, personal and inherited, you will wonder

that a large proportion of the eye cases that one sees, one has to look for the cause of the trouble outside and beyond the eye.

The most common general cause of eye disease is syphilis, and probably half the cases of iritis, vitreous disease, choroiditis and retinitis may be put down to this poison, and it is a pretty safe general rule to make, that when in doubt in any of the above to give some form of mercury and iodide of potash.

I have met with a large number of cases of interstitial corneitis, almost invariably from inherited syphilis, and nearly all of those have got well under specific treatment, although the course of cure may run into many months and sometimes years. The diagnosis is easy from the well-know accompanied signs in the teeth, nose, etc., and ground glass appearance of the cornea.

Kidney disease is a prolific cause of eye disease, the disease almost invariably affecting the retina, so that no apparent cause in the eye is seen until an ophthalmic examination is made. The two conditions to think of is that of pregnancy, or immediately after it, and Bright's disease. On examining the urine the presence of albumen will lead you to a diagnosis.

Tobacco poisoning.—The excessive use of tobacco is the most common cause of toxic amblyopia. I had a very severe case last year at my out-patients, but he recovered, as nearly all of them do, when the cause is cut off. As a rule there is not much difficulty in getting the patients to give up the use of tobacco in these cases, as the threatening of loss of sight acts as a very strong deterrent.

Diphtheria —Everyone now knows the difficulty of reading that often comes on after an attack of diphtheria from paralysis of the accommodation. But if you order a pair of plus glasses, to remedy this defect, be sure and not forget to order their discontinuance when the paralysis of the muscle has passed off.

Rheumatism.—This is supposed to be a common cause of conjunctivitis, and of that particular form of iritis called relapsing. I often have thought that rheumatism, and so-called "cold" have been mixed up together. I have not found that these cases particularly are benefited by anti-rheumatic remedies. I have found that soothing applications are more beneficial than astringent ones in so-called rheumatic conjunctivitis. As regards the iritis atropine is as necessary in this form as in every other form of iritis. I have seen conjunctivitis and iritis from gonorrhœal rheumatism, but it is not common.

Gout.—In the conjunctivitis of gout, the general system should be treated at once ; the eye trouble is only an outpost. It is in this disease that one meets with those sudden cases of blindness, complete or partial, from rupture of an atheromatous vessel in the retina. Hæmorrhagic retinitis. Whether we meet with conjunctivitis, iritis, hæmorrhage, or glaucoma in gout, the general treatment is more important than the local.

In *nervous diseases.* In all cases of brain disorder the eye should be examined by the ophthalmoscope. Eye changes are common in these diseases, such as syphilitic growths, meningitis, abscess, &c.

In *leucocythæmia, pernicious anæmia*, and *purpura* we meet with retinal hæmorrhages.

In *pyæmia* and *septicæmia* we meet with purulent conditions, which I have seen ; here, as a rule, removal of the eye is necessary.

The troublesome tinea tarsi of *measles*, the *cataract of diabetes*, the vague eye symptoms of *alcoholism*, we all know.

I have said enough. I have left plenty of gaps for you to fill in. Suffice to say that the study of the eye will always repay one, and give us many clues to some of our most perplexing cases.

Pass List.

Royal College of Surgeons of England, November, 1902.

FINAL EXAMINATION FOR THE FELLOWSHIP.

F. G. Cross, H. T. Hicks, A. R. Thompson, N. F. Ticehurst, R. H. J. Swan.

PRIMARY EXAMINATION FOR THE FELLOWSHIP.

A. B. O'Brien, H. C. Cameron, A. H. Miller.

Final Conjoint Examination, October, 1902.

Medicine, Surgery and Midwifery.—*E. Faulks.

Medicine and Surgery.—P. W. Hamond.

Medicine and Midwifery.—*A. J. Beadell, F. W. Fawssett, L. S. H. Glanville, W. C. Lewis, F. L. Thomas.

Surgery and Midwifery.—W. F. Box, A. W. Iredell.

Medicine.—*H. Bentley, *F. D. S. Jackson, *R. C. Lawry, *G. S. Robertson, *H. Tipping.

Surgery.—*W. L. M. Day, *J. W. Gromitt, W. Johnson, G. Moir, *L. H. Moiser, *S. L. Pallant, *T. M. Smith, A. H. Turner.

Midwifery.—C. E. Bartlett, P. C. V. Bent, J. Braithwaite, J. Bromley, C. H. Dawe, C. F. Fraser, E. G. Goldie, G. W. C. Hollist, A. P. Piggot, W. W. Read, E. W. Strange, O. B. Travers.

* Denotes completion of examination.

Second Conjoint Examination.

V. A. P. Costobadie, W. C. M. Dickey, J. A. C. Greene, H. M. Langdale, G. W. de P. Nichols, G. W. R. Preston.

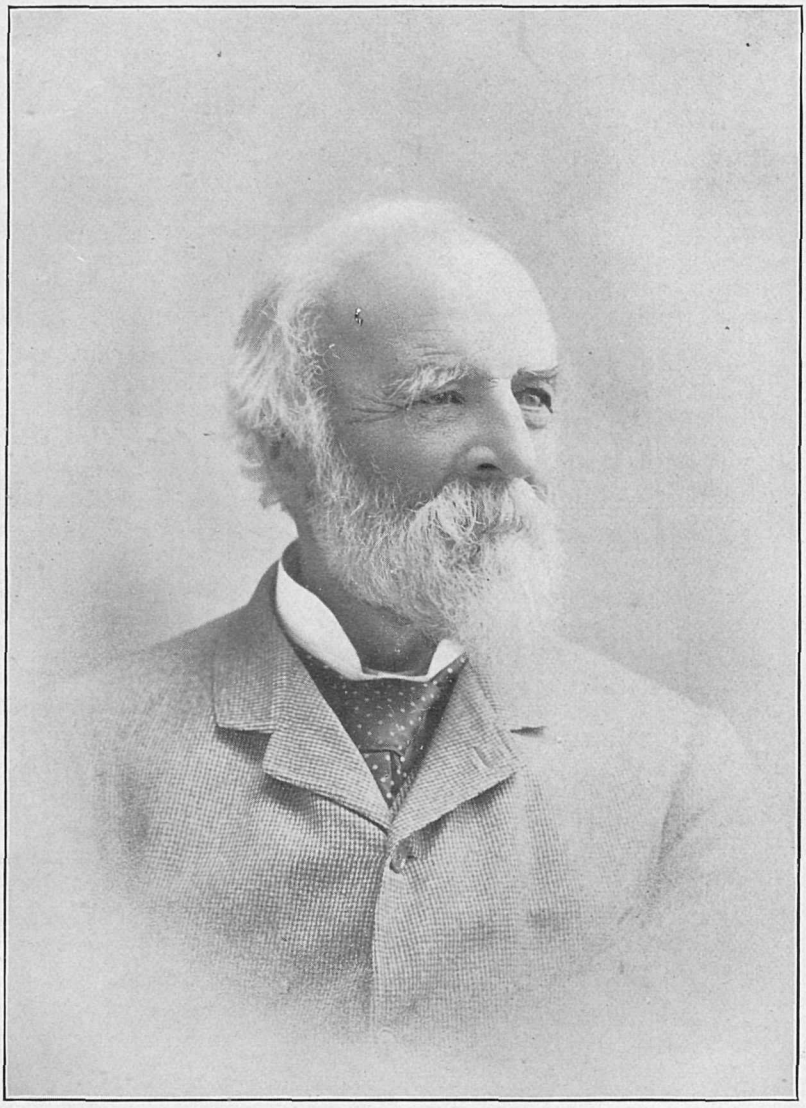
First Conjoint Examination.

Chemistry.—H. E. W. Williams.

Elementary Biology.—E. P. Minett, J. F. Ramirez.

Practical Pharmacy.—E. Faulks, †A. E. Rowlett, R. S. G. Seagrove.

† Materia Medica and Pharmacy.



HENRY OLDHAM, M.D., F.R.C P

Born January 31st, 1815. *Died November 19th, 1902.*

Obstetric Physician 1849—1868

Obituary.

Dr. Henry Oldham.

Dr. Henry Oldham, for many years obstetric physician and lecturer on Midwifery at Guy's Hospital, died at Boscombe, Bournemouth, on Wednesday, at the advanced age of 87. Dr. Oldham was the third son of Mr. Adam Oldham, of Tooting, Surrey, and was born January 31st, 1815. He entered the medical profession as a student at Guy's Hospital, and in 1849 was appointed to the active staff of the hospital as physician accoucheur and lecturer on midwifery and diseases of women. On his resignation in 1869 he was appointed consulting obstetric physician, a post he held at the time of his death. Dr. Oldham contributed numerous and valuable papers to the various medical journals on the work of his special department, and was one of the first supporters of the Obstetrical Society of London, of which he was successively president and treasurer, He was a successful and popular teacher and a most impressive lecturer, fixing the attention of his crowded audiences by his eloquence, the incisiveness of his style, and by the charm of his fine voice and presence. He held a high position among obstetric physicians, and for many years his practice was a very large one. From this he retired some eighteen years ago to Boscombe, Bournemouth, where he resided till his death. He married in 1838 and leaves two daughters, married, and one son, Colonel Sir Henry Oldham, lieutenent of the Hon. Corps of Gentlemen at Arms. His wife predeceased him in 1885.—*Times*.

Dr. Oldham will always fill a large place in the history of the hospital, and in the special history of the gynæcological department. He was early attached to it, and was before qualification the junior Charity, and contributed notes to the first volume of the Guy's Reports published in 1836. He passed the M.R.C.S. in May, and the L.S.A. in September, 1837, the year of the late Queen's accession, assisted Dr. Ashton in the Charity and in Petersham (now no longer an obstetric ward). He contributed regularly to the Reports in conjunction with Dr. Lever (the famous discoverer of uræmia fits in pregnancy, known as eclampsia, a title since more widely extended), with whom he was associated in the investigation. His name lives still in the well-known "Oldham" perforator.

He was, on the recommendation of the Court of Committees, appointed with Dr. Lever one of the first obstetric physicians to Guy's Hospital in the year 1848, and as the records of the Charity date from 1833, he may be considered to have been intimately connected with the records that have since become famous. His industry was great, and we hear of him performing "the cæsarian section" successfully, mother and child both living in 1850, an account which includes a description of the action of chloroform in the case, a comparatively new drug. We are informed that he introduced the use of the microscope in Guy's, and to him we owe a great deal of our knowledge of minute anatomy. The printed descriptions in the reports bear evidence of his recognised position as a mordid anatomist. He well remembered the days when ovarian cysts were operated on without anæsthetics. He was not a great believer in drugs, except quinine, ergot (? secale cornutum in his reports) and cascara. He believed in careful dieting and in hygenic living. We believe he suffered from a compensated mitral stenosis and a pre-systolic murmur to the end of his active life.

His most noticeable characteristics were his fine presence and his manner, his striking and handsome appearance, and his skill and eloquence as a lecturer at a time when lectures were not received with great reverence. He had a large and busy practice, and to the end of his long life he maintained the closest interest in all that appertained to his old hospital and school. The remote antiquity at which he laboured (speaking medically) may be gauged by the fact that Sir Samuel Wilks took notes of his lectures, Sir Henry Howse was one of his Charities, and the late Dr. Braxton Hicks was his assistant obstetric physician. He was the lecturer on midwifery and the diseases of women and children, the latter part being nowadays nowhere provided for in the hospital lectures.

The record of his appointment by the Court of Governors adjourns an interesting entry in the minutes of the Governors' meeting appointing William Withy Gull, who had assisted the Apothecary, to continue to assist the Apothecary (Mr. Stocker) and to assist Dr. Ashton and another department at the remuneration of £100, "it appearing to the Governors that his assistance had been valuable."

It was as a lecturer that his name was most famous, and there are extant still some stories of his ready repartee.

Washbourn Memorial Fund.

FOURTH LIST OF SUBSCRIPTIONS.

The following subscriptions have been paid:—	£	s.	d.
Subscriptions previously acknowledged . .	117	12	0
Mr. Thomas Bryant	2	2	0
Dr. Goodhart	2	2	0
Mr. C. Higgens	2	2	0
Dr. Sykes	2	2	0
Mr. F. Newland Pedley	2	2	0
Dr. E. W. Goodall	2	2	0
Mr. K. Goadby	2	2	0
Mrs. R. T. Jones	2	2	0
Sir Henry Howse	1	1	0
Mr. C. Stonham, C.M.G.	1	1	0
Mr. J. H. Badcock	1	1	0
Dr. E. B. Forman	1	1	0
Mr. W. Hancock	1	1	0
Dr. H. M. Stewart	1	1	0
Mr. H. K. Lacey	1	1	0
Dr. A. H. Partridge	1	1	0
Mr. E. Henderson	1	1	0
Dr. H. Starling	0	10	6
	£144	7	6

A. P. BEDDARD, Hon. Sec.

44, Seymour Street, W.

Ashwell not Ashton.

Contributions.

He was a well-informed coroner who loved to dazzle his jury with intellectual dash, and he was eliciting his own theory by the usual skilful leading questions, and he enquired of the medical witness, concerning an alcoholic consumptive recently deceased.

"Do you believe much in the open-air treatment, Doctor?"

To which the police-surgeon answered in a solemn still tone without changing a muscle, and his face wearing an expression that was partly that of a man patiently seeking after light and partly a man compassionate for weaker men—

"Can't say I think standing outside public houses is much use," and the subject dropped and was gone like a jelly fish on the hot sea sand.

The young and earnest "druggist" had equipped the astonied Borough porter with matutinal confection of sennæ, predigestive stimulants, and post-prandial digestive patents, but his enthusiasm was quite damped when the following week the patient explained that he didn't want the pomatum any more, which reminds us of the man who drank the boracic acid ounce by ounce, and applied the acid and alkaline aperient effervescent preparations alternately to his pointing abscess, and informed his doctor the medicine suited very well and the two bottles certainly did cool the inflammation but they did hiss so!

We are accustomed to receive presents galore, and strange and fearful tales of cures from the hand of the advertiser and quack, but we are not so sure the following letter received by the wife of a medical man, for whom she once ordered some cigars, does not betray an attempt to out-Herod Herod and oust the Yankee in the great game of spoof:—

> Dear Madam,
>
> You are critical in your taste and no doubt when selecting, like to indulge in a quiet smoke. This is not possible in the Showroom of a Cigar Merchant, but is possible in your "den," where there are no disturbing influences.
>
> Under these circumstances a man no sooner gets a cigar in his mouth than he becomes a philosopher. "It calms his body, sweeps away memory of petty irritating annoyances, stimulates his mind, reveals himself to himself, consoles him for past blunders, inspires him to better things in the future."
>
> Isn't it worth your trying our cigars under such conditions?
>
> There are a few pleasant things in life. The sampling of our cigars from original boxes is one of them.
>
> We are, Dear Madam, Yours,

Alas! we fear that this is not the real thing. It is but a lath painted to look like iron, and is rather the daring amateur wit of the clerk than the studied aggression of the professional advertiser.

"I was both H.-S. and H.-P." added the coroner, parenthetically.

"Really!" acquiesced the A.H.-S., anxious to be polite and interested; and he wondered why the coroner seemed a little distant and frosty.

The Ward Clerk rushed into the Ward in haste. "There is a bad 'fractured base' coming in and it is on the way up." But the ministering angel, calm and collected, with her "Lamb's" eye upon her and her lectures fresh in her memory, had already gripped the situation. "Please wait till we are ready. Put up a fracture bed, please nurse."

GLAUCOPIS.

Sport.

Rugby Football.

GUY'S A. v. ST. THOMAS'S A.

Played at Chiswick on Wednesday, November 26th. Guy's turned up two short, minus a forward and full back. The game for the first five minutes was of a scrambling character, but the result of a bout of passing. Hicks ran down the line and scored wide. Shortly after Guy's began to press, the ball being in the loose was picked up and passed out to Reinhold, who ran round and scored near the touch line. At this moment Hogarth and Bridger appeared, and strengthened by this reinforcement, Guy's completely held the upper hand, and in a forward rush Russell got over the line. Score at half time—Guy's 3 tries, St. Thomas's nil.

Guy's again began to press, and Willan kicked up the field and the ball was well followed up by Hicks, who raced with the opposing back and touched down wide. From the drop out St. Thomas's carried the play to half way and an exchange of kicks by the two full backs. Bridger, with a long kick, found touch close to our opponents' line, and Wall, securing the ball from the throw out, dropped over the line and scored the fifth try. After this play was of an even character and confined to half way, when a St. Thomas's three-quarter intercepting a pass, looked dangerous, but was well brought down by Bridger.

Nothing further was registered until the call of time. Not one of the tries were converted, being wide, and the ball being heavy and very slippery. Thus the game ended, Guy's 5 tries 15 points. St. Thomas's nil. Team :—

GUY'S.—R. Bridger (back); J. T. Hicks, P. L. Pallant, C. H. Reinhold, G. Russell (three-quarter backs): R. Willan, F. Cutler (half-backs): A. E. H. Wall, S. M. Saunders, A. M. Tolhurst, T. B. Layton, H. M. Clarke, F. Hogarth Kidd, Davies-Colley (forwards).

GUY'S 3RD XV. v. LONDON HOSPITAL 3RD XV.

This match was played at Hale End on Wednesday, November 5th, resulting in a win for Guy's by 1 goal, 1 drop goal, and 2 tries (15 points), to 2 tries (6 points). Saunders opened the score for Guy's by dropping a goal from near the half way line. Saunders also scored 2 tries and Gibson 1 try. Team :—

GUY'S. — G. N. Bartlett (back); Gibson, Helyar, Watson, G. Wacher (three-quarter backs); Myott, Kynaston (half-backs); Saunders, Ball, Dowdney, Davies-Colley, D. Reynolds, Roberts, L. Reynolds (forwards).

GUY'S 3RD XV. v. OLD CHARLTONIANS A.

This match was played at Charlton on Saturday, November 8th, resulting in a win for Guy's by 1 goal, 1 drop goal, and 1 try (12 points) to nil Kynaston scored 1 try, Edsall 1 try, and Husbands 1 drop goal. Team :—

GUY'S.—Husbands (back); Wight, Watson, Edsall, Gibson (three-quarter backs); Kynaston, C. P. Harvey (halves); Metcalfe, Dowdney, Davies-Colley, Smart, Helm, Roberts, Myer, L. Reynolds (forwards).

GUY'S 3RD XV. v. DULWICH COLLEGE 2ND XV.

This match was played at Dulwich on Wednesday, November 12th, resulting in a win for Guy's by 1 goal, 1 drop goal, and 3 tries (18 points), to 2 goals and 1 try (13 points). Kynaston scored 2 tries and 1 drop goal, Burney 2 tries. Team :—

GUY'S.—Husbands (back); Burney, Kynaston, Edsall, Gibson (three-quarter backs); Willan, C. P. Harvey (half-backs); Saunders, Pinching, Tolhurst, Metcalfe, Dowdney, Davies-Colley, D. Reynolds, L. Reynolds (forwards).

GUY'S 3RD XV. v. WASPS 3RD XV.

This match was played at Uxbridge Road on Saturday, November 22nd, resulting in a win for Guy's by 1 dropped goal and 1 try (7 points) to nil. Harvey dropped the goal and Russell scored the try. Team :—

GUY'S.—Husbands (back); Reader, Watson, Gibson, Helyar (three-quarter backs); C. P. Harvey, Russell (half-backs); Watts, Metcalfe, Batt, Davies-Colley, Smart, Dowdney, Roberts, Myer (forwards).

GUY'S 3RD XV. v. LONDON HOSPITAL 3RD XV.

This match was played at Honor Oak Park on Wednesday, November 26th, resulting in a win for Guy's by 4 goals and 2 tries (26 points) to nil. The following scored tries—Brown 1, Gibson 1, Helyar 3, and Ball 1. Team :—

GUY'S.—E. A. Collins (back); H. F. Wight, H. S. Brown, H. G. Gibson, W. A. Helyar (three-quarter backs); E. C. Myott, C. P. Harvey (half-backs); B. B. Metcalfe, M. Ball, L. Dowdney, H. D. Smart, D. Reynolds, O. Roberts, M. R. Smith, L. L. C. Reynolds (forwards).

GUY'S 3RD XV. v. LONDON AND WESTMINSTER BANK 3RD XV.

This match was played at Honor Oak Park on Saturday, November 29th, resulting in a win for Guy's by 4 goals and 3 tries (29 points) to nil. The following scored tries — Husbands, Wight, Kynaston, Gibson, Willan, Harvey, 2. Team :—

GUY'S.—Husbands (back): H. F. Wight, A. E. Kynaston, H. G. Gibson, W. A Helyar (three-quarter backs); R. Willan, C. P. Harvey (halves); H. Watts, T. B. Layton, B. B. Metcalfe, M. Ball, L. Dowdney, H. D. Smart, D. Reynolds, L. L. C. Reynolds (forwards).

Association Football.

GUY'S v. BECKENHAM.

This match was played at Beckenham on Saturday last, and resulted in a win for Guy's by 2 goals to 1. Guy's won the toss and Beckenham kicked off against the wind. Neither side was at full strength and Guy's played ten men the whole way through. The first half was very even, Beckenham scoring first after a quarter of an hour's play. Guy's equalized by means of Barber just before half-time. In the second half Guy's were very busy round their opponents' goal, but failed to score for some time. At last from one of Barber's innumerable wheezes, Norton scored the winning goal and the game ended as stated. Team :—

GUY'S.—E. A. Collins (goal); A. G. Jones, A. D. Crofts (backs); A. Zorab, A. F. Denning, L. H. Frankenberg (halves); A. W. Berry, H. Barber, E. L. R. Norton, F. Hogarth (forwards)

GUY'S 2nd XI. v. SOUTH NORWOOD.

Surrey Junior Cup—Second Round.

This match was played at South Norwood on November 8th, under circumstances which rendered football difficult. Losing the toss, we kicked off uphill with the sun and wind at our backs, and for some time play was of a loose character. After our opponents had been threatening our goal, our forwards broke away, and Wilson made a long shot, which scored. Play then became brisker and our opponents equalised. Before the whistle went, Wilson, by a good individual effort, scored a second point. Upon resuming, our goal-keeper was kept well employed, but played a sound game, and although we continually pressed, no goal was scored. Several times our forwards got away, and at length Barlow scored. An obvious penalty for us was disallowed on the evidence of a linesman, and soon after our opponents put on a second point. Only a few minutes were left, but Barlow took the opportunity to add another point for Guy's by a really good bit of work; Guy's thus winning by 4 goals to 2. Team:—

Guy's.—H. B. Turner (goal); Houchin and Leeming (backs); P. P. Cole, P. Pedrick, H. Perkins (half-backs); P. A. Peall, T. F. Wilson, A. S. Littlejohns, S. H. Barlow, H. Miller (forwards).

Remarks.—Many of the mistakes were doubtless due to the condition of the ball and ground, but the wing forwards played a very weak game, and the passing of the halves left much to be desired. Turner, in goal, played a good game, and Wilson and Barlow were noticeable forward.

Guy's Hospital Lawn Tennis Club.

At a General Meeting of the above Club, held on Wednesday, October 22nd, with Mr. Lane in the chair, the following officers were elected for the ensuing season. President: W. Arbuthnot Lane, M.S. Vice-President: J. Fawcett, M.D. Captain: T. C. Lucas. Hon. Secretary: F. W. M. Palmer. Committee: Messrs. C. J. Pinching, B. H. Wedd, P. C. V. Bent, C. D. Pye-Smith, A. Zorab, M. Earle and F. Cutler.

The past season has been most disappointing as owing to the bad weather only five matches have been played of which two were won and three lost.

In the Inter-Hospital Cup Ties we beat St. Bartholomew's by eight events to four—winning the singles by five to one and the doubles being left drawn at three all. In the second round, however, St. George's beat us by ten events to two, and were themselves beaten by London in the final.

The Second VI. have been unable to play any club matches as the Clubs' Union refused to make a grant for that purpose; but the team entered for the Junior Inter-Hospital Cup, and won their tie in the first round against St. George's, who retired when Guy's were leading at six to one. In the second round St. Thomas's beat Guy's easily, and eventually won the cup.

The usual Tournaments were held in June and July, and a large entry was obtained. The Open Singles for the Championship Cup were won by T. C. Lucas; the Handicap Doubles were won by J. S. Cooper and F. Alcock (rec. 15), and the Handicap Singles were won by T. C. Lucas (owe 15'4).

Papers by Guy's Men.

With Dr. Donald Hood, in the Wards of the West London Hospital.—*The Clinical Journal*, 15th October.

Infantilism and Senilism. By Hastings Gilford, F.R.C.S.—*British Medical Journal*, 1st November.

The Sero-Therapeutic Treatment of Epilepsy: A Criticism. By James W. Russell, M.A., M.D., M.R.C.P.—*The Birmingham Medical Review* for September.

The Exaltation of Bacterial Virulence by Passage Outside the Animal Body. By E. W. Ainley Walker, M.A., M.D., Oxon.—*British Medical Journal*, 18th October.

Some Cardiographic Tracings from the Base of the Human Heart. By Astley V. Clarke, M.D. Cantab., and J. Sholto C. Douglas, Christ Church, Oxford.—*Journal of Anatomy and Physiology* for October.

A note on Age as a Factor in the Ætiology of Lead Poisoning. By James W. Russell, M.A., M.D., M.R.C.P. *Birmingham Medical Review* for October.

Note on Nitrous Oxide Gas, Air, and Chloroform as a Mixture. By Tom Bird, M.A. Oxon., M.R.C.S. Eng.—*Lancet*, 8th November.

Three Cases of Hour-Glass Contraction of the Stomach Treated by Operation. By Hastings Gilford, F.R.C.S. Illustrated.—*British Medical Journal*, November 8th.

Clinical Remarks: Round About Constipation. By James F. Goodhart, M.D., LL.D. Aberd.—*Lancet*, 8th November.

The Value of Rest as Effected by Operation in the Treatment of Certain Diseases of the Alimentary Canal. By A. Ernest Maylard, M.B., B.S. Lond.—*Glasgow Medical Journal*, for November, 1902.

Fæcal Fistula complicating Tuberculous Peritonitis.—*Clinical Journal*, 29th October.

Death after Removal of Tonsils and Adenoids in a Hæmophilic Child. By Francis J. Steward, M.S. Lond., F.R.C.S. Eng.—*Lancet*, 15th November.

The Croonian Lectures on the Natural History of Pneumonia. By the late J. W. Washbourn, C.M.G., M.D., F.R.C.P. Lond. Illustrated. Delivered before the College of Physicians of London and edited by J. W. H. Eyre, M.D. Durh.—*Ibid.*, 15th October.

Convulsive Disorders in Infancy. By George F. Still, M.A., M.D., F.R.C.P.—*Clinical Journal*, 3rd December.

Ed.—J. M. B.

Contents.

	PAGE
A MERRIE CHRISTMAS	509
MALIGNANT ENDOCARDITIS: Clinical lecture by Dr. Hale White	510–517
GUY'S HOSPITAL PHYSICAL SOCIETY	517–521
APPOINTMENTS	521
PASSIM	523–526
PASS LIST	526
COPY OF ORIGINAL GRANT IN COUNTING HOUSE, GUY'S HOSPITAL...	527
THE LITERARY CLUB SMOKING ROOM	527–528
CORRESPONDENCE: The Modern Use of the Curette ...	529
GUY'S HOSPITAL PHYSIOLOGICAL SOCIETY	529
GUY'S NURSES' CHORAL SOCIETY AND STUDENTS' GLEE CLUB	529–530
HYPOPLASTIC TEETH	530–532
SAMPLES	532
THINGS REFLECTED ON	533
PAPERS BY GUY'S MEN	533
SPORT: Rugby Football—Guy's v. Old Merchant Taylors; Guy's v. London Scottish. Association Football—3rd Team. Guy's Hospital Chess Club. United Hospitals Hare and Hounds. Hockey Club	534–536
REVIEWS	536
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	536

Calendar of Coming Events.

Dec., 1902.

Sat. 20.—Messrs. Golding-Bird and Dunn's take-in: Drs., H. O. M. Beadnell and R. St. G. Seagrove; Cl., A. H. E. Wall.
G.H.R.F.C., II., Polytechnic, home.
G.H.A.F.C., I., South Eastern College, home.
II., Parthians, away.
First half of Winter Session ends.

Thur. 25.—Christmas Day.
Out-Patients' Tea.
Concerts in the Wards.
Messrs. Jacobson and Fripp's take-in: Drs., F. P. Hughes and A. M. Webber; Cl., M. J. Rees.

Fri. 26.—Boxing Day. Medical School Office closed.

Jan., 1903.

Sat. 3.—G.H.R.F.C., I., Old Leysians, away.
II., Surbiton, home.
G.H.A.F.C., I., Old Reptonians, home.
II, Sevenoaks School, away.

Guy's Hospital Gazette,

DECEMBER 20, 1902.

A Merrie Christmas.

FOREIGN to all our ideas, yet welcomed by all, as a type we would admire, the English Christmas is an old-established, old-fashioned entity we would never wish to lose. To the young it suggests a partial period of carnival—the mistletoe, with the mystic sanction of ages and Druidical blessings attaching to the ancient customs, making us half Pagan as we reflect, and more than superstitious as we try the fates, —the Yule log, emblem of camaraderie, jokes, jests, walnuts and wine, both exemplify freedom from convention, familiarity without insolence, and above all a conduct without reproach or backbiting—the burning Christmas pudding, the centre of the family circle, the central emblem of what is, in truth, the hard Englishman's only tenderness—weakness, if you will— of "Home, sweet Home."

To the world it suggests a time of rest, to the old a time of reflection on fleeting time, to the strenuous it comes as a period of relaxation.

It has a wondrous charm, this period of old-forgotten heathen custom, with its ready pardon for youthful zeal and indiscretion, its general feeling of kindness, and the return to our religious and earlier training. There are few, if any, to whom the Christmas Bells and Carols do not appeal, in whom they awake no responsive memory.

Man clings to his earliest recollections, and nowhere more than in England and at no time more than at Christmas.

Stereotyped the conventional Christmas story, unaltered and unchanging the Christmas joke, it is a season of joy and gladness without precedent among nations and incomprehensible to outsiders; with ourselves it is a time of self-sacrifice, exile from our homes, and it is, too, a time when the stern fight against disease seems relaxed, though unwelcomed reminders are often in our midst, it shews the medical and the nurse in unexpected lights to each other, and it is all for good, this development of a softer side, the extension of pity to the suffering and of sympathy to the weak.

Christmas without twilight, without decorations, without self-denial and generosity, it were never the glad time it is—the apotheosis of home ideas, the central part of the family existence.

Malignant Endocarditis.

CLINICAL LECTURE BY DR. HALE WHITE.

November 8th, 1902.

GENTLEMEN,—I think perhaps we better, first of all, get quite clear as to what the phrase Malignant Endocarditis means, and I think it is taken to mean a non-rheumatic form of endocarditis due to pathogenic micro-organisms on the inflamed endocardium. I think we may add, in order to complete the description rather than to define it, that there is a great tendency for a piece of inflammatory material to become detached from the endocardium and to be carried to the peripheral vessels, which it may block. Also to add to the description, we may say that almost invariably it is the endocardium of the valve that is primarily affected, but in some cases another part of the endocardium is secondarily infected. We may further add that occasionally very similar cases occur in which the lining of the aorta is affected rather than the endocardium of the heart. There are a few cases occasionally seen in which you have an acute inflammatory process of the aorta usually not far from the valves, exactly like malignant endocarditis, but the process is outside the heart. I have tried to make clear to you exactly what the disease is, and now we will take some cases of it. They are very common and so we must restrict ourselves to three that I have seen quite recently.

The first case we will take is a woman who was in No. 24 bed Miriam. She was seventeen years of age when she came in on the 22nd July. She told us she had rheumatic fever at the age of ten, that she had been breathless ever since, and that she had rheumatic fever again when she was sixteen. She also told her clinical clerk that she had been very sick recently and had diarrhœa. On admission, on 22nd July, her temperature was 103°, pulse 90, respiration 32. The impulse of the heart was in the nipple line She had a loud systolic murmur indicative of mitral regurgitation, showing that she had had endocarditis as a result of her previous rheumatic fever. There were some râles and rhonchi in the lungs, and trace of albumen in the urine, her spleen was enlarged and she sweated profusely. The next note I have put down in the abstract of the report I have made is dated a month later. On August 29th, we can say that ever since she came in she has had an up-and-down temperature. The temperature was somewhere about 102° to 103° in the evening and several degrees lower in the morning, and this occurred almost every day. She looked thinner than she was a month before, she was remarkably pale, she sweated profusely. She had had antistreptococcal serum but it had done her no good. A month later, September 29th, we can say much the same. She had got weaker and paler with a temperature of 103° in the evening, and still sweated profusely. On October 3rd, when I took charge of the case, she was in much the same condition. Mr. Owen Richards counted the blood and the white corpuscles numbered between 10,000 and 11,000 per cubic millimetre, and the reds 3,952,000. On the same day patient had great pain and tenderness in the splenic region, also a very remarkable attack of collapse. The pulse suddenly ran up to 160 and patient appeared to be dying, breathing rapidly, and she was in a profuse sweat. From this attack of collapse she only revived after taking ether and brandy. On October 13th we discovered that she had a diffuse retinitis in both eyes. There was exudation into the retina and minute hæmorrhages, and the optic disc was blurred and inflamed. She remained in much the same general condition as last mentioned until she died from exhaustion a few days ago, and here are the viscera. One point that I omitted was, she had had some rigors soon after admission, and a striking mental characteristic was her remarkable cheerfulness right up to the end. She always thought she was getting better and asked to be allowed to get up; even a day or two before she died she was taken out of her bed and placed on a sofa so that she might believe that it was the beginning of her getting well.

The next case I take is Mary B., aged fifteen, in No. 31 bed. She came in on September 1st. She had had rheumatic fever when seven years of age and when fourteen years of age and has not been well since. For the last two days before admission she had been sick, and had a pain on

the left side and was very pale. She had a rigor three days before she came in. On admission she was very pale and anæmic. She perspired profusely. The apex of her heart was about one inch outside the nipple line, and she had murmurs indicative of mitral regurgitation and obstruction. The spleen was enlarged and the pulse 112. On October 1st it is noticed that the temperature has been up in the evening and down in the morning. She is more anæmic and thinner and perspires very much, and has some albumen in the urine. She has had one or two rigors. On October 10th Mr. Owen Richards found the blood to be sterile, red corpuscles 3,760,000, white varied between twelve and thirteen thousand, hæmoglobin 50 per cent. On October 21st she had an attack of cardiac failure, the pulse became rapid, the temperature shot up, and the patient perspired profusely and seemed as though she would die, but she was relieved in the same way as the other girl. The remarkable part of her case was that the apex of the heart moved further out during this attack of collapse. In other words, she had an attack of acute dilatation of the heart, for the apex was felt two inches outside the nipple although previously it had been one inch. Two days later there is a note to say that she had been sick, that the dilatation had passed off and the apex had returned to an inch outside the nipple line. On October 26th she had paralysis of the left external rectus and diplopia. On October 28th she is noted to have just the same condition —but in a less degree—in the retina, as our first case. This second patient also had retinitis, some minute hæmorrhages, and the optic disc was swollen and blurred. On October 29th she had a hæmorrhage under the skin on the back, and there was blood in the urine. On November 1st, still more important symptoms were noted because she had right hemiplegia, the face and arm and leg being affected.

Here are notes of a case that I saw this week that I thought would help to complete the remaining symptoms of malignant endocarditis. The patient is a young man, aged twenty-two, whom I first saw on October 20th with Dr. Guy Hollings. He had had bad aortic disease for years. Two weeks before I first saw him he was suddenly taken with a rigor, and since then he has had an irregular temperature, usually 103° in the evening and 99° in the morning. He had another rigor two days ago, he sweats profusely and looks very pale. He has been sick. His lungs. urine and abdomen and optic discs, my note of October 20th says, are perfectly healthy, and there is no evidence of emboli. A diagnosis was made that he had malignant endocarditis. I saw him again last Thursday and his temperature had varied every day from 103° in the evening to 99° in the morning. He is paler, weaker and thinner, and sweats profusely. He has had no more rigors. His murmur is much harsher. He has several purpuric spots under his skin, and several retinal hæmorrhages. Now I come to an interesting point which led me to introduce this case. The patient had uræmic symptoms a few days ago, blood appeared in the urine. Yesterday pus was noticed in the urine, a thick deposit of pus, and the urine was scanty. He had only passed four ounces in the previous twenty-four hours when I saw him. He had some œdema. We had still no evidence that he had got infarct in his spleen. (I subsequently heard he died the same evening.) Those are the three cases that we shall take as a text for to-day.

In regard to the nomenclature of them, you will find some books call this disease *malignant endocarditis*. That name explains itself; it is malignant in the sense that it is usually fatal. Other books call it *ulcerative endocarditis*. That is because the acute process in the valves leads to considerable ulceration of them. But it is a bad name because ulceration does not always happen. Others, particularly the Germans, like to call the disease *septic endocarditis*. The patient is certainly almost always infected with streptococci, and in that sense the disease is septic. But one of the best names of the disease was given by Sir Samuel Wilks forty years ago; he called it *arterial pyæmia*. That is a good name because it fixes upon you the important fact that one of the chief characteristics is that you have a pyæmic condition of certain arteries. He wanted to show that it was a disease in which minute pyæmic fragments from the valves were carried by the

arteries to the distant arterioles, which they blocked. Still, the name does not matter much so long as you know what the disease is. Many micro-organisms can cause it, but in nearly all the cases the offending micro-organism is some virulent form of streptococci. Other organisms which may cause it are, first in frequency, the pneumococcus, next the gonococcus. Rarer ones are the micro-organisms of typhoid, anthrax and diphtheria and the bacillus coli. Dr. Goodhart pointed out that in the days when pyæmia was frequent in the hospital, the cases of malignant endocarditis rose and fell in frequency with those of pyæmia.

I have notes here of a bad case that we had in the ward some years ago of gonorrhœal malignant endocarditis. The patient was aged nineteen, and came into Stephen ward on September 23rd, 1895. Four weeks ago he contracted gonorrhœa, and during the four weeks he had several severe rigors, by December 3rd he had eight more rigors with often a temperature of 105°. On October 5th a diastolic murmur was found in the third left space and his spleen was enlarged. On October 29th the spleen was enlarged more. There was a diastolic and systolic murmur heard in the pulmonary area. He had rigors, consonating râles, and pneumonia, he had also blood in his urine, and diarrhœa, and finally he succumbed as most of these cases do. The gonococcus was recovered from the valves in that case. Here was a case following a severe attack of gonorrhœa, and the clinical interest of it was that the murmur was not developed until the patient had had his acute infection some time. You will notice that he came in on September 23rd and had no murmurs until October 5th, and then they were pulmonary.

To go over the disease, I think the first organ we had better take is, of course, the heart. Nearly always, when malignant endocarditis affects the left side of the heart, the disease supervenes upon old chronic endocarditis. If you will look well at this heart from our first patient, you will see the mitral valve is thickened and evidently there has been old rheumatic endocarditis, and there you can see the acute inflammation with the formation of these vegetations implanted on the old process. All the cases that I have mentioned to-day illustrate this point. Both the women in Miriam and the man were known to have endocarditis on their left side before the supervention of malignant endocarditis. So bear in mind that when this disease is left-sided it almost invariably supervenes upon old endocarditis. It is important to remember that it is just the reverse on the right side. When it supervenes on the right side of the heart, almost invariably there is no previous endocarditis to account for it. Thus it comes to this: that practically speaking malignant endocarditis is the only cause that we know of right-sided endocarditis supervening subsequent to birth. That fact is of great importance in diagnosis. You remember only a moment ago that the man who was in with gonorrhœal malignant endocarditis had no cardiac symptoms until he had been in ten days. Then murmurs were heard, systolic and diastolic, over his pulmonary valve, indicating pulmonary obstruction and regurgitation. That absolutely clinched the diagnosis in favour of malignant endocarditis, because we knew he had not got those murmurs when he came in. We knew also that virtually the only cause for organic murmurs developing after birth on the right side of the heart is malignant endocarditis. Here was a man in whom such murmurs developed, and so we knew that he had right-sided malignant endocarditis. I remember a case in Philip in whom murmurs had developed at the tricuspid valve, and they developed under our observation, and we said therefore that the man had malignant endocarditis, and we were right.

I find that here at Guy's we have about one case every year of malignant endocarditis on the right side and that the tricuspid valve is affected four times as often as the pulmonary, which is what you would expect, because the source of infection of malignant endocarditis on the right side of the heart is generally some disease in the periphery and the infective material is carried to the heart and infects the tricuspid valve, coming to it before it comes to the pulmonary valve. Very often after death you cannot find a primary source of infection. I remember that in 1886 I made a

post-mortem on a man with malignant endocarditis of the pulmonary valve, so severe that the ulceration right through the valve was big enough to let a No. 12 catheter through, and yet we failed to find the source of infection. While we are on the subject of diagnosis, going back to the left side there is a statistical collection of these cases by Dr. Frederick Taylor in the Guy's Hospital Reports. He finds among those he collected that twenty-three were mitral, three aortic and thirteen both mitral and aortic. You may ask me very fairly, "Can you tell whether the process going on in the valves is increasing or diminishing?" It is very difficult to give an opinion on this point, but many think, and I think too, that sometimes you can successfully infer that the process is going on acutely because the murmur becomes very harsh or sometimes very musical. This seems to indicate a rapid process in the valve. I remember when seeing the man whose case I have read, on the second occasion, that his aortic murmurs were much harsher than before.

The next thing we have to consider is the effects of the disease upon the arteries. It is one of the features of this disease that pieces of infective material from these vegetations are carried from the heart to different parts of the body. The most obvious thing would be that a large artery should be blocked. That is exceptional. But small infarcts are very common. It is quite a common thing in the spleen or in the kidney for an artery to be blocked and for an infarct to result. What happens when an artery is blocked is that the part supplied by the artery undergoes coagulation and necrosis. Some infarcts are white and some red, and the difference depends on some ill-understood different blood-supply. This viscera that you see illustrate the well-known fact that infarcts are usually white both in the kidney and in the spleen; usually in the intestine and lung they are red.

Another effect that may occur from blocking of an artery besides an infarct is that the part may undergo necrosis. That is what happens in cases where there is not lymph to undergo coagulation; for example, in the nervous system the cerebral softening results from blocking of an artery.

Another event is that if the embolus that is carried to the part is very septic, the resulting infarct breaks down, and an abscess forms. In the man whose case I read, I mentioned to you that the urine contained a quantity of pus. What happened in his case was, no doubt, that the infarct occurred in the kidney and suppurated and broke down. Here (in this specimen) is the same thing in the spleen. There has been an infarct, and, as a result, an abscess has formed. Abscess resulting from infarct is not an uncommon thing.

The next thing that may occur—our cases illustrate it—is that as the result of an embolus carried to some part, you may get hæmorrhage. We cannot go to-day into precisely why it should occur, but one causative factor is the blocking of a vessel. You see that in red infarcts. Also we may regard it as merely an expression of the severe septicity, so to speak, of the embolus. There were many instances of hæmorrhages in our cases. In the girl in No. 31 bed, and in the man whose case I read to you, there were hæmorrhages in the skin. In all three cases there have been hæmorrhages in the retina. Sometimes the patients get hæmoptysis owing to pulmonary infarction.

The last result of embolism I want to bring before your attention is an aneurysm. Sometimes an embolus blocks an artery, the blood-supply is cut off from the wall of the vessel, and the wall becomes inflamed from contact with the septic embolus, from these causes the wall just centrally from the block dilates and an aneurysm forms. I have seen many instances. Perhaps the most striking was a student who was under my care in Clinical years ago. He had pneumonic malignant endocarditis and became jaundiced. We could not quite understand why he should become jaundiced. He died quite suddenly and there was found a ruptured aneurysm on one hepatic artery. He had got, because of his endocarditis, aneurysms on both of his hepatic arteries. They pressed on the bile-duct and made him jaundiced, and one ruptured and killed him. It is curious that these infective aneurysms are often bilateral

in situation. He had one on each hepatic artery. You might say that that is not unlikely because a large embolus from the heart might get broken at the bifurcation of the vessel and so a piece would find its way to each division, but this explanation does not always hold, for I remember a case in Stephen, years ago, in which both vertebral arteries had an aneurysm on them as the result of malignant endocarditis.

The next point is you will say, "Can you during life tell when an infarct has occurred in an internal organ?" I think you often can. In some of our cases the patient complained of sudden and severe pain over the spleen. I have brought down this specimen, showing an infarction in the spleen, and I think one symptom that should lead you to suspect such a condition of spleen is sudden and severe pain. Then too, in the case of the spleen there is sudden increase in the size of it. If the infarcted organ is one that discharges externally, you will get hæmorrhage. When an infarct occurs in the kidney there is blood in the urine, if in the intestine there is blood in the motions, if in the lungs there is hæmoptysis. So that the symptoms by which you may diagnose whether an infarction has occurred are, sudden and severe pain, some enlargement in size, and bleeding. The spleen and the kidney are the commonest organs to have an infarct. In about one half of the cases of malignant endocarditis the spleen or kidney, or both, are infarcted. The brain comes third and is affected in one third of the cases. That is exactly the proportion in our three cases, for we have one in which the patient has hemiplegia. I may remark that if the brain is affected, the patient will almost certainly have hemiplegia.

The kidneys are of great importance in malignant endocarditis. They may have infarcts in them, but in addition there is a condition of kidney peculiar to this disease and which our post-mortem showed, and which you will find in almost every case if you look for it. The kidney is almost always large and the capsule peels easily. When it peels off you see it speckled with red spots, as if it were flea-bitten. You see some red spots on section. There is some alteration in the epithelium, because the kidney appears to be of a pale, yellow colour, rather than normal. This change is of very great importance for this reason, that it may lead to the patient suffering from the effects of the kidney disease. The man whose case I read had uræmia. Supposing the kidney symptoms are very prominent, supposing that because of an infarct in the kidney the man has pain in the loins and hæmaturia, and because his kidney is in this speckled, pale condition, he gets some uræmic symptoms and his temperature happens to be a little raised for a few days after you see him, you might regard him as a case of acute renal disease supervening on chronic, and set down the cardiac symptoms as due to affection of the heart secondary to the kidney. We had such a case not long ago. We thought it was a case of Bright's disease, and regarded the affection of the heart as secondary to it. I might also remark that hæmorrhage in the eyes, which may occur in malignant endocarditis, might in such a case be regarded as due to Bright's disease.

I have already described the optic changes in malignant endocarditis. What I want to bring before your mind is what I think some of you do not know—is that these changes are not by any means uncommon. Both patients in Miriam had optic neuritis and retinitis and all three cases had retinal hæmorrhages. I do not think it is sufficiently known, because some surprise was expressed that these retinal changes should occur in the patient in No. 24 bed. They are often of great help in the diagnosis of malignant endocarditis, and you will notice that not only is there optic neuritis and hæmorrhages, but in addition there is a diffuse retinitis. In the cases which Dr. Frederick Taylor collected he pointed out the importance of these symptoms in connection with diagnosis. Occasionally an embolus occurs in the central artery of the retina.

With regard to the blood examination for organisms, it is often negative, as it was in these cases, although after death they are found easily in the valves. Usually speaking, although the disease is septic there is not a high proportion of leucocytes. I think the reason why the leucocytes are comparatively low—they were

somewhere about eleven or twelve thousand in the patients in Nos. 24 and 31 beds Miriam—I think the reason is because the infection is often so severe that the body cannot react and so lead to any prominent leucocytosis. That explanation will hold with regard to the patient in No. 24 bed, because she died from the disease; and there is no chance that she in No. 31 bed will recover.

You will remember that in the first lecture I gave you this winter—on typhoid fever—I pointed out that malignant endocarditis may occasionally give a Widal reaction. I have mentioned one case here with hæmorrhages in the skin. In addition to that the patient may sometimes get a septic rash. I saw a fatal case in August in which the patient had a well marked rash, but neither her doctor nor I were sure whether it was rheumatic or septic.

Then you will notice that the pulse is increased and that the temperature is very irregular. That leads me to say that I think some text-books do not lay sufficient stress upon the fact that in most cases of malignant endocarditis the temperature is pretty uniformly considerably higher in the evening than in the morning. Another point of interest is, that the respirations are sometimes not increased in frequency quite as much as you would expect, considering how high the temperature is.

You will notice that the patients have rigors, and I think it is important to remember that that is an early symptom. Our cases to-day all illustrate that towards the end of the disease rigors often cease.

The patients are much more anæmic than an examination of the blood would lead you to expect. So marked is this anæmia that it is quite a point to help you to diagnose the disease.

The sufferers sweat very profusely indeed. There are few diseases in which the patients sweat more.

They frequently have profuse diarrhœa, and as it is probably to some extent eliminative you must not be too ready to stop it. They are often sick.

They are certainly often optimistic. This man who was passing pus in his urine was, a few hours before he died, discussing where he would spent the winter, and what he would do, when he would play cricket again. These patients do not seem to realise how ill they are. This was certainly true, you will remember, of 24 Miriam.

Another point. Our cases illustrate that malignant endocarditis is a disease of young people. It is rare in old people. The ages of the girls we have got are fifteen and seventeen, and the man whose case we took is twenty-two. There is nearly always a murmur, but in some cases, like the gonorrhœal case, there is for some time no murmur, and then the diagnosis is very difficult.

Speaking of the diagnosis, that is of great importance. Usually by the time you see a patient he has had a raised temperature for such a period that most specific fevers are out of court. So that you have before you the problem, What can be the matter with a patient who has a raised temperature and has had it for some little time? It may pass through your mind that perhaps he is a patient who has heart disease and has typhoid fever also. Apart from the spots, what will particularly help you is the blood examination, because the leucocytes are usually considerably diminished in typhoid fever, and even if they are not increased in malignant endocarditis they are not diminished. The Widal reaction will help you in many cases, but not, as I have already shown, invariably. But this will help you; repeated rigors are rare in typhoid, profuse sweats are rare in typhoid, whereas they are the rule in malignant endocarditis. Then again the temperature in malignant is generally markedly of the up-and-down type. In typhoid the temperature usually keeps more nearly level. The tongue may help you, and if you get a culture of streptococci from the blood that will clinch the diagnosis, and lastly the retinal changes may help you in this and many other difficulties of diagnosis.

Another condition that is difficult to diagnose and will tax your powers to the utmost is that the patient may have some deep-seated pus. That difficulty is what you would expect, because it is a streptococcal infection in both cases. You must carefully go over every possible position of pus—the rectum, the

teeth, and the ears—and be on the look out for any local tenderness. As an illustration, take the man in No. 8 bed, in John ward, who has had suppuration in his leg and has pyæmia. If he had a murmur he would become almost a case of malignant endocarditis The point is of considerable importance, because if the patient has malignant endocarditis he will probably die. One thing that will help you very considerably is the blood-count, because usually in malignant endocarditis there is not so great a leucocytosis as in suppuration.

Influenza may bother you if there is an epidemic of influenza, but the immediate prostration in a case of influenza, and the pains, and the temperature not being of the same type will help to put you right. Here the blood examination will be of great service, because influenza is a disease in which there is no leucocytosis.

I think that perhaps the most difficult disease to distinguish may be acute tuberculosis. There may be difficulty if there is no murmur present; or an organic murmur may be regarded as hæmic. In both diseases the temperature may be the same; the rigors and sweats may be the same. Although meningitis certainly occurs with malignant endocarditis, the supervention of meningitis may help you to say that a case is tuberculous. You will go over the lungs, and particularly and usually the first indications that you get of tuberculosis in such a case are increased respirations out of proportion to the temperature, and a little lividity usually seen about the lips or finger nails. If you can find streptococci in the blood so much the better. I have known questions turn up as to whether the patient was suffering from phlebitis or malignant endocarditis without a murmur. That is pretty much the same difficulty as we have had in connection with pus. But if a patient has phlebitis, usually there is some local pain to help you, and then the symptoms are very much more severe, as a rule, in malignant endocarditis.

Ague in parts where the disease exists might lead to great difficulty—and does so, especially in the Southern States of America—in diagnosis. But if you will examine the blood in such cases you will generally make a correct diagnosis.

Another point of great difficulty is that, supposing a patient gets a mild attack of endocarditis, you may not be able to say at first whether it is rheumatic or malignant. The patient has previously had rheumatic fever and now he has endocarditis, and very often you really cannot say which of the two forms he is suffering from. If he gets well you usually assume that it was rheumatic endocarditis, but the proof that you are right is difficult; if he does not, you come to the conclusion that he is really suffering from malignant endocarditis.

The difficulty that might arise between this disease and kidney affection I have already referred to.

Then if the patient has no murmur and is a girl, say, of the age of seventeen, when this disease usually occurs, the question may arise in your mind whether the temperature is what is called a hysterical temperature. You will really never have any difficulty in connection with that, because you should never diagnose temperature as due to hysteria until you have watched the patient for a month, for the condition is so rare, and a mistake is so disastrous, and if you watch the patient for a month the malignant endocarditis will have shown itself by then.

I think one point of great practical importance in connection with diagnosis is this. If you suspect that the patient has malignant endocarditis you are nearly always right. It is a disease which is much more overlooked than is diagnosed correctly.

The prognosis, I am sorry to say, is bad. I have seen a man with rigors and pain and tenderness over his spleen, and raised temperature, and murmurs, in whom a diagnosis of malignant endocarditis was confidently made, but who got quite well. But such cases are the exception. There is no doubt about the grave prognosis in all the three cases I have taken. Two are dead already and the third cannot recover.

What to say about cases that come into the hospital, doubtfully rheumatic, or malignant endocarditis, is a difficult question, but

probably if they get well and go out the disease was not often malignant endocarditis; a blood examination for streptococci may be great help in this and other difficulties. You must remember that this disease may last some time. I jotted down some cases which I took from the hospital records, and I see that one case had been eighteen weeks in the hospital, another eight and a half weeks, another four months. It may be, therefore, a slow disease.

That brings me to another point which I may say struck me frequently with regard to the case in No. 24 bed, and also struck me in the two other cases. These patients go on for a long while, and yet they look so ill at times that you think they must soon die. The case in No. 24 bed frequently looked so ill that we were surprised the next day to see her alive. She went on six weeks looking like so.

With regard to the treatment, I regret to say there is very little that you can do. Of course the ideal thing would be to give the patients efficacious antistreptococcal serum. I have given it to many cases but I have never seen it do any good whatever. Although a few cases are published in which it is said to have done good, you have to remember that mistakes in diagnosis are sometimes made. The patient may never have had malignant endocarditis at all, and the published successful cases are very few indeed. Nevertheless, as it seems the ideal treatment, I go on using the serum, hoping that I may come across a case that will be benefited by it. But you must not go away with the impression that because you cannot do any good in the way of actually erradicating or neutralising the disease you cannot benefit the patients. You can help them very much. With regard to the case in No. 24 bed, she got some bronchitis, with most troublesome cough, and we gave her some heroin, which relieved her greatly. You can relieve the vomiting and pain, and also the diarrhœa, if necessary. Although I have not been able to recommend a specific cure, still you must not go away with the impression that "it does not matter" as you cannot effectually treat the disease. It matters very much indeed that you should find out what is the matter with your patient, because the first step to treat a patient is to find out what is the matter. It is a matter of very great moment indeed to decide whether a patient has got malignant endocarditis or typhoid fever.

It is an example of what is true for several diseases, namely, that medicines are of little curative use, but the art of medicine is invaluable as, in the first place enabling you to find out what is the matter with the patient, and in the second place helping you to make their distressful condition somewhat comfortable.

Guy's Hospital Physical Society.

A Meeting of the Society was held in the College on December 3rd, 1902, Mr. G. G. Davidson in the chair. Mr. H. Barber read a paper on—

HYPOCHONDRIASIS.

Gentlemen,—It is a difficult thing to choose a subject. I haven't studied any books more advanced than Ostler's Medicine; I cannot think of any disease in which I have a special interest; and what have I seen that you have not seen? So I have chosen Hypochondriasis, a disease which is constantly turning up, but a disease which I think, we usually neglect. We do not find it necessary in hospital practice to take it very seriously; it is a condition which is not easy in many cases to benefit; yet it is a disease, and a fairly common one, and I suppose ought not to be neglected.

Now to take hypochondriasis as a subject and not to speak of the disease as seen in the medical may be depriving myself of much copy in which I am in need of, but I don't feel equal to the task. Either I should insult my friends by speaking of them or be more wearisome than needful by speaking of my own diseases. So my attempt has simply been to collect cases of hypochondriasis from the hospital out-patients.

Dr. Taylor tells his ward clerks to collect and arrange all the facts, and to leave those who have had more experience to draw the conclusions, and, it seems to me, that that is the proper spirit for one of these papers: but in this case you will come to the conclusion that I have not collected much in the way of facts.

When I say that I take a disease that is somewhat neglected in a hospital, I do not mean to imply that I shall get anything of practical value out of it; my intention is to bring out the more obvious difficulties I meet with and I shall not ask for questions from you so much as for your answers.

So to start I take my definition, and in Dr. Taylor's Medicine it is written that hypochondriasis "consists in a morbid anxiety on the part of the patient as to his own health and a morbid magnification of his sensation, so that he imagines illnesses that do not really exist."

And again later, "the diagnosis of hypochondriasis rests upon the manner of the patient and the nature of the complaints, combined with the absence of all serious disease—lesions may sometimes be present which will not, however, account for the intensity or abundance of the symptoms."

For working purposes, I suppose, we may say that a hypochondriac is one who imagines himself to be suffering from illnesses that do not really exist in him, and this is quite satisfactory for those of us who have read up a few diseases. At times we have suffered from a growth in our rectum, at others we have been in the initial stages of typhoid fever, but occasionally a patient turns up who is trying to be a hypochondriac, but has nothing so definite to catch hold of. It just wants a suggestion to start him off, and he or she can usually obtain that suggestion by seeking advice. We all remember how Jerome K. Jerome found, on looking up his symptoms, that if it had not been for the want of a prepatellar bursa he would have been suffering from every known disease; and I quote a case of a patient who arrived at the Maze Pond entrance and said that she had been afraid something was forming in her left side; her doctor had not examined her, but suggested that it was probably a movable kidney, and she had better go to a hospital, and she was convinced that he was right, she herself could feel it move about at times. She received a sufficiently long examination to be reassuring, if not very skilful, which detected nothing abnormal but the evidence of flatus, but in spite of this I expect she is still going about sorrowing over that most terrible of diseases nephroptosis.

Now perhaps you will say that before considering such a subject as this, before diagnosing the absence of all serious disease, a man should have many years' experience, and if you do say this, well, I agree; but life is too short, and opporunities too few, and most of us in practice will have to consider such mild cases of hypochondriasis as these to which I wish to draw your attention this evening. I think it is their mildness that makes them important; their troubles are severe enough to cause them a great amount of misery. Remembering that their disease is of a mild form should make us hopeful of doing them some good. Yet many of them have long been under treatment by their doctor without any change, or if they have changed they have become a little worse. Possibly their somewhat indefinite complaint has been localised, in which case I should say they are distinctly worse.

In hospital life, for example, as dressers in the surgery, we send these people away with a card; we have not time, desire, or need to consider them; but when they turn up to attend here regularly, as out-patients, they ought to be considered. What I mean is this, that if we wonder sometimes, as we must do, whether they are not wasting their money, when they get medicine at threepence a time, and advice gratis, which they dont't come for and seldom listen to, how much more will our consciences prick us at the price of half a crown or half a guinea, as the case may be, and yet they are people who suffer much but whose hypochondriasis is of a mild form, and I suppose if a disease is of a mild form it should be curable or at least in should improve.

I think sometimes a good deal may be done for them; what I wish to urge here is that an occasional thought as to the way in which we may benefit some hypochondriacal patient we may meet will be by no means wasted. I think it is right to say, that in the main we neglect them in a hospital, and although to neglect a woman with an obscure set of symptoms may be better than to tell her she has a moveable kidney. I see no reason why we should not sometimes think of them with a view to treatment; they are often very irritable people; they are, however, always interesting; they present many points for consideration when it comes to treatment.

Now the amount of worry these patients cause themselves is very variable; there is an old man, aged 81, attending out-patients, suffering from aortic stenosis and regurgitation, who comes up every week to have a chat; there are no signs of failing compensation; he is not taking digitalis; he has no pain; so far as I know he has never been told that his heart is diseased; he always seems quite happy. Well, suddenly one day, he said that when he counted his pulse that morning he found that it was only beating twenty times in half a minute; on being asked why he counted it, he said he had counted it for years, that it used to be over thirty beats to the half-minute but that now it was often as low as twenty-six, but that he had never found it as low as twenty before; he had nothing more to tell about it; he gave no reason why he first began to count his pulse, he laughed over it and seemed quite happy. I suppose that he is not really hypochondriacal but at times he must be very near it. It would require a very lethargic man to count his pulse for several years and never imagine any evil thing.

As a contrast there is an unmarried woman, thirty years old, with a slightly enlarged soft, freely movable gland in the inguinal region, who came saying that she had a tumour which she had had for some months but that it was now beginning to "weaken her vitality." She looked excited; she obviously felt ill and worried. On taking her temperature it was found to be 103°; there were, however, no symptoms of fever; the temperature at the next visit was normal and the patient said she felt reassured, on the third visit she explained it all. Her sister had lately had a cancer of the breast; she thought this enlarged gland was a cancer; she thought that it was gradually weakening her. It must, I think, require a considerable amount of emotion to make the temperature rise to 103°: her present complaint is possibly cured but her future may reveal all sorts of troubles.

A man, aged 23, would take an intermediate position; he had suffered from pains under the heart and palpitation, especially at night, and one day he noticed that he could see his heart beating. He had cycled a good deal

during the last few years and this he suggested as the cause of the troubles; he volunteered that he did not smoke; he said definitely, when asked what was the matter with him, on first entering the room, that he had heart disease; his heart appeared to be quite healthy, the impulse was in the fifth space internal to the nipple line; his chest was thin and the impulse easily seen. Of course he only belonged to the enormous band who describe their indigestion by saying that their heart's so bad; but he took it more seriously than many because he was examining his cardiac impulse and he knew the cause of his heart disease.

Well, there are others, but these three people seem to be examples in different degrees of trouble along the same lines; the first perhaps has not made any diagnosis, but the other two have made up their minds that they are suffering from some definite disease and may be taken as fair examples of hypochondriasis; how firm their faith may be in their own diagnosis is very hard to tell or how much faith they would put in any medical advice; doubtless in many cases they are not much impressed, but, however impressed they might be for the time, their future happiness may very well be less secure than if their diagnosis were correct.

These sort of people would wander along from one brass plate to another, or would change their diagnosis from one disease to another; they would always present themselves as suffering from some more or less definite and rational complaint. They may be clinically, or perhaps rather socially, more or less separated from the cases of hypochondriasis which end their days in an asylum, about such cases I am not pretending to relate; there is, however, one case, a woman aged twenty-six, who has something crawling in her brain, who perhaps, to put it bluntly, might be described as mad. I don't know what species of animal it may be, but potassium bromide has not as yet destroyed it. If the truth were known, I expect neither of us ever thought it would.

As an example of a case where definite organic disease is present, there is a woman, aged thirty-seven, suffering from phthisis, who one day having a pain in her epigastrium said she was afraid there was something the matter with her liver. As a case of hypochondriasis she is not of much importance, but it raises the question of the liver and hypochondriasis which is somewhat difficult. People have for so long been allowed to say that their livers are out of order, when they are suffering from a certain set of symptoms, that we are always hearing of livers. I remember Professor Starling, when lecturing on digestive fluids, said that an Englishman was quite happy when you told him of his liver, but what a shock you would give him if you so much as mentioned his pancreas.

There are some people who seem to enjoy talking about their organs, the sort of people who, if they have a pain across the back say that their kidneys are out of order and they frequently seem rather pleased. Treves, speaking of a case of enteroptosis in a woman, says "she spoke of her kidney with precision and of her liver with regret." The former organs were prone to unreasonable congestion and the latter to an obstinacy which appears to have been little short of intelligent.

I suppose these people are not hypochondriacs; if a woman says her kidneys ache and by that she means she has a pain in the back, it may simply be taken as a figure of speech, though literally she has claimed a diseased organ which does not exist in her.

A woman, aged 32, who so far as I could find, had no organic disease, said that she had a pain in her liver; she admitted that by this she meant in her right side. She then said that her kidneys ached and by this was found to mean she had a pain across the lumbar region of the back. She finished by saying that of course her nerves were out of order, and in saying this I think she cannot be accused of imagining a disease which does not exist in her. If these people are not hypochondriacs they present as many difficulties in treatment. She told me that one of our obstetric physicians (I forbear to give his name) had treated her for some time with salicylate of soda and that this had made her much worse. She appears to have been satisfied with one visit to out-patients as she has not returned. Some day her name may appear as an advertisement for pills that have worked wonders where countless doctors failed—yet she is right, her nerves are out of order, and there should be some more scientific cure.

I was once in a chemist's shop when a seedy looking young man came in and asked the chemist for a bottle of tonic, and he got it. It is easy to say what a bad system this indiscriminate prescribing must be (quite apart, of course, from the chance of overlooking some serious disease), and yet when these people come to us they come for a bottle of tonic just the same. If there is an opportunity to give them good advice, if there is some obvious River Jordan to which we may direct them, we find it is not what they came for, and so they do not listen. Perhaps sometimes the only way to administer a scientific cure would be with a stick.

Of sexual cases there is one, an unmarried man of twenty-five, who described his trouble by saying that his nature was running away from him, his chief trouble was nocturnal emissions. He, again, was satisfied with one visit, there has not been opportunity to study him in full.

When first I decided on my subject I began to collect statistics, not because I thought they would be of any use, but I thought they would lend an air of definiteness to what I realised would in the main be a somewhat fanciful paper, but so many people turned up asking to have their heart sounded, or their chest examined, that there would be great difficulty in drawing the line.

Then there are those women with all the subjective symptoms of the change of life, they probably do not in many cases suffer much from real hypochondriasis, they are certainly too talkative to make much out of.

So having talked of the hypochondriacs who may come up in any medical practice imagining some disease, having mentioned a case that suggests insanity, and

another case where their is organic disease as well as mental disease, having talked of the people who locate their every symptom to some organ or another, having mentioned a case of sexual hypochondriasis, and having wisely left the old ladies suffering from the misery of the menopause alone, I am left stranded high and dry when it comes to treatment.

I suppose the treatment of these people, who are healthy in body, but imagine themselves to be suffering from some common, every-day disease, is the treatment most worthy of consideration. These form the largest group, they must be the most regular attenders at one door or another, it seems such a small step from misery to happiness, and yet they cannot take it.

To discuss the treatment of any disease in the abstract is more or less absurd, hypochondriasis is not at all adapted to it.

In Dr. Taylor's Medicine it says, "that the ailments must not be entirely ignored, nor must their importance be confirmed by too numerous prescriptions." Well, in fact once more, we have to try and hit the happy medium.

On one side, there is the chance of a simple reassurance with regard to some imagination of the patient; on the other, is a great show of treatment with many bottles of medicine, or even putting him or her to bed.

The simple reassurance in many cases would not be enough; these people suffer from such obscure diseases, frequently, that it is not easy to give sufficient proof in support of our opinion—what proof can I give that woman that she has no animal crawling in her brain; she knows it's there and how do I know it isn't?

If a man is worried about his heart, if he imagines he has what the public call heart disease, a disease which they think usually terminates in a sudden death, there is great hope of reassuring him after a careful examination, there must be opportunity for showing much discrimination in so reassuring him; and in some cases, in cases where there was some excuse for his imagination, I suppose that he will be cured once and for all. But if he imagines a disease without any excuse it will probably not be sufficient to disprove his diagnosis to him, for him there will be a tendency to find some other troubles in himself and this tendency will require more skill to combat.

Looking at the possibility of putting such people to bed or of making some other show of treatment for a time, the first difficulty that presents itself is the fact that these patients usually choose some more or less incurable condition; certainly there are many other objections to putting a man to bed who is healthy in body, and then bluffing him that he has been cured of some disease.

The happy medium usually means treating the patient for some trouble of his digestion, of his bowels, or perhaps even of his nerves; here again there must be scope for a good deal of skill in choosing the right line of treatment, and yet there are plenty of hypochondriacs so treated, who, though they will always belong to the milder type who come before the general practitioner, and not to the type who see the specialist on mental disease, will go from bad to worse till the result is a very pitiable specimen.

Many such people are so irritating, seem such an insult to the human race, that we feel inclined to dismiss them without considering their case, but even if we feel we cannot cure them, they are really as worthy of consideration, I suppose, as a man with a growth in his liver.

The chief hope of cure must lie in getting these people interested or busy in their work; the prognosis is said to be more serious the longer the condition has lasted, and so there must be no delay. How to carry this out, in any case, probably, will not be easily said, and certainly will not be easily done.

There has been no attempt in this paper to achieve anything complete, a few cases have been mentioned which remind you of similar cases you have seen.

The facts and theories about such questions as hypochondriasis of the mind, the people who wonder if they do their duty, or of the relation of hypochondriasis to melancholia I don't pretend to know. If I may be allowed to draw one conclusion, it is this, that of all mental disorders that we may meet, assuming we go into general practice, hypochondriasis will be the one that we shall be required most frequently to treat, at any rate for any length of time, and my conclusion is that in many cases we shall feel a want of experience. How are we to hit the happy medium? I have pointed out how harm may be done, that is usually easy. I have failed to point out how we can take notice, but not too much notice of the complaints. Doubtless these patients will do best at the hands of those born with a tact for these sort of complaints, but what I wonder is, without getting hypochondriasis on the brain, or without harming the patient under examination, by giving too great prominence to his complaints, how much of such a tact may be acquired?

Mr. ROBSON considered that Mr. Barber had drawn no distinction between hysteria and hypochondriasis; many of the symptoms he gave as hypochondriacal are to be regarded as hysterical and treated as such. He wanted to know whether the Weir Mitchell treatment had been employed for hypochondriasis.

Mr. DAVIDSON thought it was open to discussion whether some of Mr. Barber's cases were to be regarded as genuine cases of hypochondriasis. In this disease the suffering should be out of all proportion to the condition found to account for it. Mr. Barber gave as an instance, a woman who had lost a sister from cancer and finding an enlarged gland in her groin thought she was similarly affected. Mr. Davidson thought this a very natural fear on the patient's part, and that it was not to be regarded as hypochondriasis. Nor did he consider that this old man who, found to be suffering from aortic disease, had been in the habit of counting his pulse for some years, a good example of this disease.

Mr. LEWIS wanted Mr. Barber's opinion as to the treatment of hypochondriasis. He thought the cases mentioned in the paper were just those the Society would like to be told how to treat.

Mr. ROBSON referring to the subject of treatment said that if we limited ourselves to symptoms we should meet with many difficulties. How would one treat, for instance, an old lady who had wind which passed up to her head giving her pain there? If one treated causes, how was one to deal with a case in which no cause could be found?

Mr. TRUBSHAW thought that in most cases some cause could be found for the symptoms though the latter were grossly exaggerated. He thought in most cases there was some digestive disorder which could be readily treated.

Mr. OSBORNE gave a case of a patient who felt certain he had tuberculous kidneys. He was told to examine his urine daily, with the result that at the end of a fortnight he forgot all about his complaint. He thought there were two classes of patients; those who took a pleasure in imaginary complaints, and those who had nothing else to do but think of their ailments.

Mr. TRUBSHAW did not hold with allowing a man to examine his urine. This would tend to aggravate his complaint. He should be made to employ his time in some other way.

Mr. BRYDONE discussed the best way of treating hypochondriasis. He thought that counting cells in urine was the way that would suit the least number. He gave an interesting example of a young woman who had seen many distinguished surgeons at different times, who had diagnosed stone in the kidney, stone in the gall-bladder, appendicitis, pelvic inflammation. She did have her kidney examined, but no stone was found; he expects that in the next few years she will have her gall-bladder exposed, her appendix removed, and that finally the gynæcologists will remove something. She has little to do but read up her ailments. He considered her to be a true hypochondriac, and that she has nothing the matter with her. The danger of telling her so would be to send her into the hands of some quack. He gave a further case of a man suffering from a very slight gleet, who stated that he had a most profuse disgusting discharge and could not be convinced to the contrary.

Mr. BARBER then replied, and a cordial vote of thanks having been accorded the reader of the paper, the meeting adjourned.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Appointments.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. G. Evans, T. Morland Smith, H. S. Brown, E. Faulks, P. W. Hamond, C. R. Howard.

Clinical Assistant in Medical Out-Patients.—Mr. H. M. Goldstein (Dr. Bryant).

Obstetric Dressers.—Messrs. K. Black, F. W. Wallace (January 1st); H. Mann, F. G. Goble (February 16th).

Dressers in the Throat Department.—Messrs. E. G. Goldie, E. W. Strange, B. H. Wedd, L. S. H. Glanville, E. H. B. Milsom, N. Ivens Spriggs.

Assistant Surgeons' Dressers.—Messrs. J. M. Barrionuevo, C. P. Harvey, J. McF. Pollard, J. E. Prentis, J. E. Spiller (Mr. Lane); J. H. Clatworthy, G. Russell, D. Isaacs, W. N. May, W. M. Mollison (Mr. Dunn); A. M. Benett, G. H. Cheyney, H. D. Wyatt, E. W. Routley (Mr. Fripp); B. B. Westlake, F. Rogerson, F. Barnes, W. Reeve (Mr. Steward).

Medical Ward Clerks.—Messrs. J. O. Musson, A. Leeming, R. Felton, P. A. S. Dyson, A. M. Roome, A. R. Beaumont, J. Cook, P. F. Minett, L. Myer, R. Edridge, S. M. Wells, A. S. Littlejohns, C. M. Stevenson, L. J. J. Orpen, E. C. Hughes, H. M. Clarke, E. W. Sheaf, N. H. Oliver, L. Doudney, R. O. Williams, H. P. Costobadie, F. M. Longson, L. J. Patterson Clavier, T. Turner, F. H. Lennox Jones, A. H. Clough, A. B. Cocker, G. F. Greening, R. P. Lewis, H. V. Mitchell, A. Morris, J. E. Scales, L. G. Davies, F. Alcock, C. M. Wenyon, R. A. Chisholm.

Surgical Ward Clerks.—Messrs. J. A. C. Greene, H. M. Langdale, C. W. R. Preston, R. W. Allen, V. A. P. Costobadie, A. D. Crofts, W. C. M. Dickey, A. B. O'Brien, M. de L. Robinson, H. C. Cameron, R. E. French, M. McPherson, G. H. H. Macalister, A. H. Miller, G. W. Nicholson.

Aural Surgeon's Dresser.—Mr. H. S. Jones (January-February).

Post-mortem Clerk.—Mr. F. C. Robinson (February-March).

DENTAL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Dental House-Surgeons.—Messrs. H. Croot, E. Farrant.

Assistant Dental House-Surgeons.—Messrs. G. L. Dymott, H. P. Hooper.

Demonstrators in the Conservation Room.—Messrs. E. N. Plummer, C. W. Randall, W. H. Edwood.

Demonstrators of Dental Mechanics.—Messrs. H. P. Aubrey, R. Glendining.

Demonstrators of Dental Metallurgy.—Messrs. F. W. Parfitt, R. Roberts.

"Guy's Smoker."

THE CHAIRMAN'S SPEECH.

Passim.

The Annual Dance took place on November 25th, in the Court Room, and proved an unqualified success. We may say, without fear of contradiction, that the staircase, ballroom, and sitting-out places have never been so beautifully and tastefully decorated before, and we must express our deep gratitude and indebtedness to Mrs. Perry and Mrs. Fagge for the energy and trouble they took over the preparations, and also our gratitude to Mrs. Perry for the kind loan of her rooms, the old mahoganies and oak of which add so greatly to the pleasures of the dance.

Mrs. Bonsor made a splendid hostess bearing a beautiful flower bouquet presented by the President on behalf of the Residents, and we were also very glad to see the Treasurer. The room was full but not overcrowded, and rarely have we seen dancing kept going so unflagging from the start nor did we detect any ladies adding to the wall decorations, a result that testifies to the zeal of the Stewards and the discretion of the ticket controller. It was a most successful evening.

The arrangements for the Dance were entrusted to other hands this year and proved eminently satisfactory. The band was supplied by Burgess, the catering by Messrs. Paul & Callard, and the champagne by Messrs. Foster & Son. The floor gave great anxiety, as a new and drastic cleaning had recently been in process, and the zeal of the carpenter had resulted in an over-development of beeswax, which had eventually to be scraped off, however, the floor improved as the evening went on. There was, in great contrast to last year, hardly a single representative of the Staff present, so many having been prevented from accepting by family bereavements. Following an innovation of last year, the Stewards invited the Sisters of the Hospital to the Dance, and we were glad to welcome them to a most enjoyable evening.

The Smoker proved, as we predicted, a great social success. The tickets did not go well, but the financial result was an equilibrium, and we are far from wishing to see them overcrowded. It was, however, a pity that the young men did not take the opportunity of supporting this hospital institution, as they missed thereby what an old enthusiast and performer described as the best smoker he could remember. The turns were really excellent, and the general enjoyment well-marked. Mr. Lucas made an excellent chairman, and his reply to his health was received with great enthusiasm. Stanley Cock returned to the scene of his triumphs, and his skill was as welcome as of yore. We had fain publish some characteristic caricatures, but as they appeal only to the sense of humour, and appear to be derogatory to the sense of dignity, only three are included with this number.

The first half of the Football season has closed, and the authorities have been enabled to take stock of our prospects before the onset of the short strenuous period that settles the destination of those cherished possessions, the Rugger and Soccer Cups, and we must say that prospect of our making a good bid to retain the one and acquire the other seems bright. But we hope the mistake of playing "old men" out of their year will not be again repeated. It served us well at Cambridge, where there is every justification for it, but if we had beaten the Scottish with our prospective cup-team, the results would have been more to be proud of. We cannot emphasize too strongly the absolute folly of not filling up vacancies instead of relying on stop-gaps. *Verb. sap. sat.*

Among the burdens we expect to cease from bearing shortly is the truly iniquitous charge known as "rates and taxes," a comparatively modern exaction as the result of the subtleties of the legal mind. The subjoined figures speak for themselves:—

St. Thomas's	...£2656
Guy's	...£2257
Royal Ophthalmic ...	...£1008
St. George's	... £827
The London	... £490
Westminster	... £138

Rates are presumably levied in the interests of the poor, and here we note that the removal of

HAROLD WATSON.

this iniquitous charge would maintain another ward that we should have no difficulty in filling with deserving and urgent cases.

The hardest worked time of the year is at hand for Residents, Sisters, Nurses, Wardmaids and all engaged in the hospital, and perhaps on that account it is also the pleasantest. Few realise the labour, the worry, and the actual fatigue that the ward concerts and nigger entertainments imply, and many prefer to ignore the somewhat obvious outlay of money. We are sorry to hear that the Christmas dinner is not so well equipped, that the Ward Funds are low, that the expenses are heavy, and we hope they may yet be met. Much money is expended at Christmas, but who can doubt that the intense eagerness that children show to come in for Christmas and to get admission to the Out-patient Tea, together with the obvious happiness of the Wards, is not a most convincing proof that the money is well expended, and we hope that the work will never stop for want of funds, though it must be borne in mind that theatrical entertainments, nigger shows, decorations and open hospitality are not recorded without someone paying the piper, and we shall be happy to receive subscriptions from any who wish that the old customs should be maintained without the burden falling unfairly on those who at present are responsible for it.

For many months past they have been dropping in upon us, welcomed and yet strange from that far-off and now forgotten land, South Africa, where as nurses, dressers and civil surgeons they have so worthily upheld our fame and carried our name to lands and races that never knew it. Sunburnt, hardy, and often moustached, they find us anæmic, pale and listless, and their boisterous spirits testify to their health and to their joy at their return.

With the return of Sisters Hyland and Rowland Jones, formerly Assistant Matron and Sister Stephen respectively, the tale must be nearly complete, and we shall have great pleasure in publishing an account of the services of the rank and file, that is the nurses and the civil surgeons who have so worthily upheld our tradition in a far off land.

With the present number the usual Christmas enclosure is issued. It was decided by the Gazette Committee many months ago to give away a facsimile of the original grant of arms to the Hospital of Thomas Guy, and the quaint

wording of the document and the magnificent length of the single sentence, in which, without stop or parenthesis, the whole matter is disclosed, cannot but prove interesting. It is interesting to note that the title King of France was still retained at that period.

The results of the exams. are well-nigh complete, Messrs. Swan and Eason (we almost wrote Edgar) have obtained the M.S.; R. P. Rowlands has obtained the B.S. and M.B. (First Class Division in Honours with Gold Medal and Scholarship in Medicine), and many others have distinguished themselves. And here we must apologise for the imperfect list supplied us in our last, which omitted the late R.M.O.B. from the M.B. list. The results of these examinations afford some interesting commentaries. Mr. R. P. Rowlands was Mr. Lucas's House-Surgeon and then R.M.O.B. (both almost exclusively surgical appointments), then he became Demonstrator of Anatomy, but in the M.B. he is distinguished in medicine, of which he should be but a theoretical student; while Mr. Abdy Collins obtains a Second Class Honour in Midwifery, and we believe this recent House-Surgeon has never even dressed in the department.

It also raises another interesting point. As Dr. Shaw was fond of pointing out, it is no uncommon thing for the anxious and highstrung student on the eve of his examination to waylay the Dean and tell him the teaching of his subject was bad and almost non-existent and to enlarge on the difficulties of the passing the exam with such inadequate instruction, as he styled it, and the late Dean further added, with a touch of insight and humour all his own, that he had grown accustomed to such periodic cries, and thought the prognosis for the individual was usually good, that he would pass, and usually he did.

This is also interesting from the fact that a common cry is that advanced medicine is *not* taught at Guy's by the Visiting staff (what they do at their visits but teach we are not told), but if there is one branch at which we shine it is medicine. The gold medal last year in the M.D., the gold medal this year, and distinctions in the M.B. last year, all medical, and yet we pride ourselves on our practical surgical experience. What does it all mean? Is it that the strongly-equipped experienced house-surgeon reads up his deficiencies more thoroughly, or that teaching is inferior to personal observation, or again, is it that the well-known Guy's dogmatism in surgical matters proves less acceptable to outside examiners? Be it as it may, it is harder for the surgeon to satisfy in surgery than for the physician, and, if anything, the surgeon gains medicine honours more easily; or is it that, as a disgusted candidate put it, hard medical questions are really surgical and vice-versa?

With characteristic dash the surgeons have started to solve the problem of when to operate on abdominal conditions, and the surgical board is now frequently inscribed with Exploration for Gastric Ulcer where the cases have come in direct from outside. In a sense it is subversive of all our customs, and it is this practical reversal of the rule that abdominal conditions are admitted under the physician, a rule that we think worked well in the past, but the increase in abdominal surgery has led the public to call the surgeon direct in many instances, often, we fancy, to the detriment of the public, as we have seen within our walls. In fact, the tendency is now rather too radical, perhaps reaction will come. It will be interesting to see how the physicians will deal with the further inroad on their position.

The physician in time past, as Mr. D'Arcy Power points out in his Elizabethan Revivals of Surgery *(St. Bart.'s Magazine)*, was omnipotent, and the surgeon's constant grievance was that they were looked upon as craftsmen, able to wield the knife and saw, but unable to order diet or medicine to their patient, a position that one well-known recent Guy's physician maintained to his last day. In 1632 it was ordered in council:—"That no chirurgeon doe either dismember, replace the head, open the chest or belly, cut for

the stone . . . . . but in the presence of a learned physician, one or more," and till recently it may be said that in the medical wards at Guy's this position was strictly observed, without ridiculous insistence however, and without friction.

The Residents have arranged to give an entertainment to the Hospital and Nursing Staff (*all* of whom will be cordially welcomed), on Boxing night and the night after, December 26th and 27th, and as far as possible the Matron has most kindly made arrangements for every nurse to attend the performance. The first part will probably be a short duologue; the second part will consist of "The Ghost of Jerry Bundler," and the "Area Belle." All the characters will be played by the Residents, for whom every indulgence is craved. The stage manager is Mr. H. M. Woodward, the property, Capt. W. H. Brailey; and the business, Mr. J. M. Brydone; and the following will act: Messrs. Atkins, Grey, Woodward, Odgers, Pearson, Robson, Brailey and Brydone. The performance, which has been unfortunately only got up at the eleventh hour, will begin at 8 p.m. punctually in the Court Room, and we hope the Staff and all the Hospital menage will take this notice as a cordial invitation.

Pass List.

University of Cambridge, November, 1902.

EXAMINATION FOR THE DEGREE OF DOCTOR IN MEDICINE.

J. H. H. Manley.

University of London, October, 1902.

M.D. EXAMINATION.

A. E. Clarke, T. H. B. Dobson, H. P. Ferraby, D. G. Greenfield, G. N. Meachen, W. T. Milton.

M.S. EXAMINATION.

H. L. Eason, R. H. J. Swan.

M.B. EXAMINATION.

EXAMINATION FOR HONOURS.—MEDICINE.

First Class.—R. P. Rowlands obtained the Scholarship and Gold Medal.

Second Class.—W. G. Mumford.

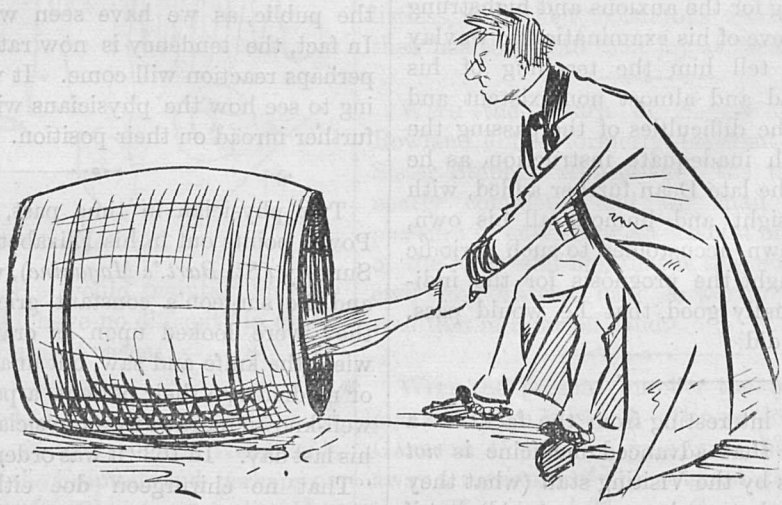
OBSTETRIC MEDICINE.

Second Class.—M. Abdy Collins.

B.S. EXAMINATION.

Second Division.—W. H. Bowen, P. W. L. Camps, M. Abdy Collins, Stanley Hodgson, A. G. Osborn, R. P. Rowlands, F. E. Walker.

"Guy's Smoker."



THE DIOGENIC "MEDIUM."

These are the Arms, Crest, Supporters and Motto, belonging to the Hospital, in the Parish of S.t Thomas, in Southwark; founded by Thomas Guy, late of the City of London Esq.r Witness my Hand. John Anstis Garter

Copy of Original Grant in Counting House, Guy's Hospital.

To . . And Singular to whom these Presents shall come or [illegible]n Austis Esqr Principal King of Arms Send Greeting Whereas the King's most excellent Majesty hath been graciously pleased to give His Royal Assent to An Act passed this present Sessions of Parliament intituled An Act for incorporating the Executors of the last Will and Testament of Thomas Guy late of the City of London Esqr deceased and others in order to the better management and disposition of the Charities given by his said last Will and who are thereby declared and adjudged to be One body corporate and politick with perpetual Succession and to have a Common Seal and Whereas Charles Joye and John Lade Esqrs two of the Executors of the last Will and Testament of the said Thomas Guy have by Letter humbly desired the Right Honourable Talbot Earl of Sussex one of the Lords of His Majesty's Bedchamber and Deputy (with the Royal Approbation) to the Most Noble Thomas Duke of Norfolk Earl Marshall and hereditary Marshall of England to issue his Warrant to the Kings of Arms concerned for their devising and with his Lordships consent and approbation granting and assigning to the said Corporation such Arms Crest supporters and Motto as they may lawfully bear and use and that his Lordship would permit the said Arms Crest and Motto to be sett upon the Monument intended to be erected to the Memory of the said Mr Guy and forasmuch as the said Earl of Sussex &c hath by Warrant under his hand and seal bearing date the thirteenth day of this instant May directed and appointed me to devise and with his Lordship's consent and approbation to grant and assign unto the said Corporation such Arms Crest Supporters and Motto as they may lawfully bear and use and that the said Arms Crest and Motto might be sett up on the Monument of the said Thomas Guy Know ye therefore that I the said Garter in pursuance of the said Warrant and by vertue and authority of the Letters Patent of my office granted under the Great Seal have devised and do by these presents with his Lordship's approbation Grant and assign unto the said Corporation the Arms Crest Supporters and Motto hereafter mentioned viz *Sable on A Cheveron* [illegible] between three *Leopard's heads Argent each crowned with an Eastern Crown of the second as many Flowers de lis Azure* and for a Crest upon A Wreath of the colours of the field *A woman sitting accompanied with three Children proper habited Azure* being the emblem of Charity the Arms supported on either side by an *Angell proper habitted Argent the hair and wings Or each holding a book proper the clasps Gold* and underneath the following Motto *Dare quam accipere* as in the margin hereof the same are more plainly depicted to be born and used for ever by the said Corporation and that the Arms Crest and Motto may be sett upon the Monument designed to be erected to the memory of the said Thomas Guy without the lett or interruption of any person or persons whatsoever In witness whereof I the said Garter have to these Presents subscribed my name and affixed the seal of my Office this twenty fourth day of May in the eleventh year of the reign of our Sovereign Lord George by the grace of God King of Great Brittain France and Ireland defender of the Faith Annog Dom 1725

JOHN AUSTIS Garter
Principal King of Arms

The Literary Club Smoking Room.

The Young Novelist had been unable to resist the seductive influence of a big fire and a good cigar. Moreover the Eminent Critic had shown himself not undisposed to listen, so in the end the Young Novelist found himself unburdened of all his aspirations, all his difficulties and all his fears.

"I suppose I may say," he said, "that I have now got over the initial difficulty of finding a suitable plot for my efforts. I used to worry a lot over the selection of something that should be both new and startling." "Without success," said the Critic, gazing intently at the fire. The Young Novelist looked up quickly—"Without success," he admitted. "I am now content," he continued, speaking more rapidly, "with an old story retold, I try and pay more attention to the evolution of my characters and I must confess that this is really a more difficult matter than the creation of a new plot. I am writing a serial for the *Autocrat* and one of my characters is to be a Hospital Nurse."

"Doubtless," said the Critic, "you pride yourself on a measure of originality in the selection of this character. You know it has been attempted by many, and by many who ought to know better. You will find all sorts and conditions of people labelled for the reader, nurse, but you will find few, if any, who can be recognised as the real and original article. So if you are resolved on the nurse in your story see if you cannot give her some claim to realism."

"She must be beautiful," said the novelist hastily.

"You insist on her being beautiful. They always are, I admit, in the story books, and you feel somewhat reluctant to run counter to the established opinions of those you would emulate. But just think for a while. Take the first hundred women that you may meet any day and anywhere and analyse their claims to beauty. You will find that only a certain percentage can urge even a moderate plea. And nurses are women, you must remember, so the same law holds good in their instance. Still I suppose I must give in and let her be beautiful. If you had merely made her charming—I use the word merely with deference—I should have had nothing to say. There are many so more charming women than there are beautiful, and I am quite prepared to admit that the

modern training of a nurse is in itself a potent factor to this desired end. So she is to be beautiful. Well, so be it. But don't make her of an ethereal or fragile beauty or any nonsense of that kind."

"Oh no," said the Novelist, "I had intended—"

"Penny and even sixpenny heroines," continued the Critic, ignoring the interruption. "Delight in hereditary tuberculosis, and thus the fiction nurse gets cast in the same mould. Please remember the physical examination of the probationer when she enters on her training; think of the years of hard work which must surely find out the weak spots in her armour of physique." The Critic paused to fill his pipe.

"I once lived with a medical student," the Novelist began, "and he said—"

"Give her the healthy glow of the milkmaid or the calm beauty of perfect womanhood—whatever that may be—but keep off the strumous diathesis."

"I beg your pardon?" enquired the Novelist.

"If she enters into your story to any great extent you will probably have to go into her early history. If you can possibly help it, without hurting your feelings, I mean, leave out the part about it being her ideal in life to nurse the sick and the poor. We have all had ideals in life—mine used to be engine-driving and later on driving a dust cart—but few of us have realised these ideals. The majority of nurses take up nursing because it is an honourable profession, the most honourable if you like, that is open for women. There are a few dreamers . . . . and they awake." The Critic sighed and remained silent for a few minutes. "So I would implore you to avoid this common error, both for the sake of the heroine and for your own sake."

"How ought I to introduce her? What about her friends and relations?"

"Curiously enough the sensational story nurse has never any relations. As a matter of fact she has got brothers and sisters as commonplace as yours or mine but they are always left out of the book. You might strike a note of originality by putting them in. Make the nurse's brother pull the hero out of a duck pond or push him in, whichever suits the plot better. Have a sister as bridesmaid at the wedding and let her father give her away. Why not, if she is real?" The Novelist coughed slightly. He was still somewhat sensitive. He was about to make a remark when the Critic continued his musings. "By now you will have thoroughly warmed to your task and will want to give particulars of her duties. I should advise you not to attempt a description of her life at a training hospital. There are too many technicalities to be mastered and too few opportunities for sensational writing. It has been attempted once or twice with the most comical results. And you don't want to be funny, do you? You will do well to keep the story strictly to her life in private nursing. There is a number of different schools from which your nurse might have hailed, and you can disarm criticism by an appeal to the manners and customs of one of these or even of a private training institution. When you have got her out in the world you will of course employ her nursing either the hero or else some person of equal importance to your book."

"It is the hero," said the Novelist."

"I thought so," nodded the Critic. It is as well to have the local practitioner in attendance as well as the nurse. Apart from the fact that nurses are only supposed to work in conjunction with doctors, you will find it healthier for your patient to have some one with some knowledge of medicine in the background. The heroine is there primarily for the due carrying out of the doctor's instructions. She does not know anything of medicine or surgery beyond what she has picked up in the course of her practical training and from attendance at compressed and often incomprehensible lectures. The nurses who write to newspapers in the advertisement column, and present their photographs and the gratuitous advice that somebody's cocoa is the best, are not the sort of people of whom you would want to make heroines. Incidentally they are not the people who get employed twice by the same doctor. And here is another warning. There will be a great temptation for you, when the hero is lying ill—don't make it brain fever, let the illness be vague, hint at symptoms that would make the family doctor turn up his Osler and meditate an article in the medical press—there will be a great temptation to permit the nurse to approach the bedside with finger on lips, and gaze earnestly at her patient. She continues to gaze some time and then gives him some medicine. This is always effective, you know, for she turns with a pious ejaculation and says that the crisis is past. Don't let her do it, please. She would not know what she meant if she did, and I am sure no one else would. I always think the first perpetrator of this rot must have had an intimate acquaintance with engines and imagined the art of nursing was similar to that of engine-driving, where one eye is always on the water gauge. Try and get the patient well by good honest nursing without any crises and without patent cocoa. Do not let nurse be appealed to as a final arbiter of his fate or if you do permit this on no account let her commit herself. She is strictly forbidden by her superintendent to attempt any prognosis. The doctor is paid (or should be) for that business."

The Critic rose and knocked out his pipe. "By this time you have probably advanced sufficiently far in your story to permit the hero to fall in love with the nurse. She has loved him all along. But you must not let her watch night and day on the strength of it. It is not the first case that she has attended and she probably knows as well as you do the necessity of a good night's sleep. When he is convalescent they can go for walks together and he can lean heavily on her arm. I don't mind that and she will probably like it; then you had better get them married quickly before he changes his mind." With this last sage remark the Critic looked at his watch and put on his hat.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Modern use of the Curette.

Dear Sir,—Would you allow me to correct an error in the number for Dec. 6th? On page 494 under the heading *Dysmenorrhœa*, it states "The patient does not complain of great pain during the periods." This is just the opposite of what was intended. In these cases she *does* complain of great pain at the periods.

Would you allow me also to state in answer to questions I have been asked since the publication of the lecture, that, firstly, the patient is always anæsthetised, the A.C.E. mixture being usually employed. It is possible, perhaps, to curette in some cases without anæsthesia, but it is very unsatisfactory, and no matter how the patient tries to bear it, she cannot help resisting more or less, with the result that the curetting is imperfectly done.

Secondly, the patient should be kept in bed about a week. I not unfrequently let them get up on the fifth day if all is going on quite satisfactorily, and let them go home on the seventh or eighth day. Most of my private patients, however, prefer to rest a little longer and go home on the tenth to the fourteenth day.—Yours truly,

42, Brook Street, W. PETER HORROCKS.

The Physiological Society.

A Meeting of the above Society was held on December 4th. Dr. Pembrey was in the chair, and a paper was read by Mr. H. O. Brookhouse on "Unconscious Mentality," The paper was of very great interest and the following is an outline of its chief features:—

After justifying the introduction of a psychical theme to a physiological society, Mr. Brookhouse endeavoured in a history and account of the arguments of either side to justify on purely philosophical grounds the existence of an unconscious mentality coexistant with the conscious. Then turning to examples he first shewed the connection and interaction of the two mentalities and then the bearing of the unconscious on habit, adding a few words on the chronology of sense development and the importance of educating the unconscious. The possibility of unconscious sensation, and the effect of unconscious mind on the body generally were next noticed. Its effects on the special senses—sight, hearing, smell, taste, and the muscular system—were briefly demonstrated, and its influence on the viscera was shown. Its bearing on disease as exemplified at Lourdes, or among the Christian Scientists, etc., was noted, and the methods mentioned of its application. Many examples were introduced to support each head. And lastly, its value to the organism and the importance of its scientific recognition was estimated, its value in philosophy, ethics, hypnotism, biology, and most important to the parent and teacher. Last of all its necessity to and usage by the physician was briefly insisted upon, and the paper closed with a reminder of its limits and employment.

Guy's Nurses' Choral Society and Students' Glee Club.

Mr. Henry Taylor is to be congratulated upon the result of the concert which was given under his direction in the Court Room on Tuesday, December 9th. It has often been our pleasure to record the success which has attended this gentleman's efforts at Guy's, but we have never chronicled a more finished performance than this, his latest.

The programme, given below, was distinctly more ambitious than in previous years, but the choice of subjects was amply justified by the result. As a whole, the choir has attained considerably more control, both in tone contrast and in attack, than in previous years, an improvement more notable, because more needed, in the male voices. The unaccompanied part-songs, for male voices only, showed a tendency to lose pitch towards the end, but otherwise were extremely creditable; indeed, the duet "The Lord is a man of War" (Handel) and Balfe's "Wine the Magician" (from the "Rose of Castile") were the best items on the programme. The first half of the evening was occupied by a series of short pieces for the choir, either as a whole or divided. Five solos were included, songs by Sister Patience, Sister Rennie and Mr. Felton, all of whom were well received, a recitation by Mr. Ray Edridge, and a pianoforte solo by Miss Taylor. Mr. Edridge chose to interpret the delicate humour of Anstey-Guthrie, and succeeded in delighting his audience. Miss Taylor, in Chaminade's "Les Sylvains," showed faultless technique and a real sympathy with her author. She played, as a well-deserved encore, Elgar's "Salut d'Amour."

The second half of the programme consisted of Elgar's Cantata, "The Banner of St George," in which Nurse Pettit took the solo very well. The only regret that could be felt in the presentation of this beautiful work was that an orchestra was not available Mr. Taylor threw himself heart and soul into the cantata, and was loyally backed by the choir. From start to finish there was a swing and dash about the performance that was most pleasing, and the verdict of the audience completed the success of the evening. Appended is the programme:—

Part 1.—Part-song, "Wake, Love, Wake" (Henry Smart), Full Choir; part-song. "The Merry Wayfarer" (Mendelssohn), Students' Glee Club; song, "Tears" (Cowen), Sister Rennie; duet, "The Lord is a man of War" (Handel), Students' Glee Club; part-song, "My Love dwells in a Northern Land" (Elgar), Full Choir; song, "The Sailor's Grave" (Sullivan), Mr. R. Felton; pianoforte solo, "Les Sylvains" (Chaminade), Miss

Margaret Taylor, and as an encore, "Salut d'Amour" (Elgar); trio, "The Snow" (Elgar), Nurses' Choral Society; part-song, "Farewell Meeting" (Mendelssohn), Students' Glee Club; song, "A Summer Night" (Goring Thomas), Sister Patience; part-song, "Slumber Song" (H. Lohr), Full Choir; trio, "Wine the Magician" (Balfe), Students' Glee Club (solo, Mr. R. Felton); recitation, "A Show Place" (F. Anstey-Guthrie), Mr. Ray Edridge. Part II.—Cantata, "The Banner of St. George" (Elgar), solo, Nurse Pettit. "God save the King." Accompanist, Miss Margaret Taylor.

Hypoplastic Teeth.

A paper read before the Dental Society on October 17th, 1902, by Mr. A. L. MASON.

GENTLEMEN,—Various names have at different times been given to teeth of defective structure, but none appear to have been very satisfactory; more recently the term hypoplasia has come into use, being first adopted by Dr. Grevers, of Amsterdam. Hypoplastic teeth may be briefly described as teeth of imperfect structure or formation, and include those generally known as syphilitic, stomatitic, mercurial, etc. Many theories have been advanced concerning the cause of hypoplasia; some of these theories we might consider for a short time this evening. Some of us are acquainted with a peculiar malformation of the permanent teeth sometimes associated with congenital syphilis. Although these teeth present such marked characteristics as to procure for themselves a distinct classification, they are also included by Dr. Grevers among the hypoplastic teeth. This malformation which was first described by Mr. Jonathan Hutchinson is most marked in the upper and lower incisors. They appear peg-shaped, are stunted, spaced, and present a crescentic notch upon their cutting edge. The tissue is of a dirty colour sometimes likened to "size" and quickly wears away. The molars are dome-shaped in appearance, said to be due to the dwarfing of their cusps, and are considered by some to be a more certain characteristic of syphilitic teeth than the incisors.

Mr. Hutchinson believed this malformation to be due to syphilitic affections of the mouth occurring after birth and so affecting the developing teeth. Tomes and Salter regard his suggestions as unnecessary, saying that syphilis is capable of perverting the nutrition of many organs and structures but is known to act with special force upon the tegumentary system of which the teeth are part. They consider that general perverted nutrition would cause the deformity rather than specific stomatitis. Tomes also attacks his opinion on other grounds. He says that specific stomatitis is said to occur in a child seldom before the second week and rarely after the ninth month of birth, and that calcification of the permanent incisors is stated by some observers to occur about the sixth or seventh month of fœtal life. If these dates were correct Mr. Hutchinson's view of specific stomatitis as cause of defect would be in danger, for the tips of the incisors which are the parts to first calcify and are the parts showing greatest defect, would be formed some eight or ten weeks before the occurrence of any specific stomatitis. If we admit that the sixth month of fœtal life is incorrect as date of calcification of the permanent incisors, and that the first month of birth is the more probable time, it seems difficult to understand how a cause acting for a few months could produce so great a deformity in the whole crown which proceeds in formation for about five years. Again, if accepting the stomatitis theory, how can one account for the deformity in the molar if their cusps are formed at birth, as they are stated to be, and specific stomatitis occurs after birth.

Mr. Hutchinson does not consider that congenital syphilis affects the temporary teeth, pointing out that specific inflammation does not occur during intra-uterine life. But remembering that at birth, half the crowns of central, less of lateral, and tip of canine are only formed, one in accepting the view of stomatitis as cause in the permanent series would expect to see some malformation in those parts of the temporary teeth which proceed in formation after birth.

Mr. Denison Pedley upholds Mr. Hutchinson's view, saying that out of the number of syphilitic children that he has examined, the vast majority possessed perfect temporary teeth. When there was any defect it was seen in that part of the tooth which forms after birth, and in such cases it was certain that mercury had been given, and he considers that mercury was the cause of defect. Whether the structure of temporary teeth are affected by congenital syphilis or not, it is generally accepted that their eruption is accelerated by that disease.

We can now consider the various opinions relating to the so-called stomatitic teeth. The teeth chiefly affected in this class are also the first molars, incisors and canines, but sometimes the bicuspids, very occasionally the second molars and rare cases of affected wisdoms have been recorded. The cusps of the first molars are sometimes drawn out and pointed and the crown presents an appearance often likened to honeycomb. The incisors are flattened and elongated towards their cutting edge, the canines have their cusps drawn out into spurious projections, and all present numerous pits and ridges and are more or less discoloured. This is a brief and general description of a typical set of stomatitic teeth but there are many modifications. The teeth may appear quite normal but for a row of pits crossing the crown, or these pits may be replaced by ridges or furrows. These defects from the slightest to the most marked are now all classed under the name of hypoplasia. Mr. Hutchinson was again the first who attempted to describe defect and cause in this class of teeth. He considered that if the bicuspids were well formed and the molars and incisors showed defect one might assume that mercury was given in some form or other during early

infancy. This he believed to cause stomatitis of sufficient severity to affect the developing teeth. For this reason he named them mercurial teeth. Mr. Hutchinson's views concerning mercury as cause have been somewhat questioned. Many patients have normal teeth to whom powders known to contain mercury were given during infancy. Again, patients possess the defective teeth to whom no powders were given—but as Tomes suggests it is quite possible that a nurse administered them apart from the parent's knowledge in order to secure her own repose.

The majority of teething powders in the market contain mercury; the majority of children are given teething powders, therefore we might argue that the majority of children should possess hypoplastic teeth. But such is hardly the case.

Tomes quotes the case of a patient with well-marked mercurial or hypoplastic teeth who admitted that for some affection he was practically fed on calomel during his early childhood. But may not the disease have caused defect apart from remedy? Knowing that such a severe condition as necrosis of the jaws may arise from the use of mercury in adults, one may be inclined to think that small doses frequently administered to an infant can occasion stomatitis sufficient to affect the developing teeth. From these facts we see that there are points in favour and against the theory of mercury as cause of defect. Probably we should be correct in supposing that mercury, frequently given to infants who are especially susceptible to its action, may sometimes produce hypoplastic teeth but that it is by no means the chief or only cause of dental hypoplasia.

Recently Mr. Norman Bennett has investigated this subject and the mercurial theory seems to be quite passed over. He prefers to divide hypoplastic teeth into two classes. In the first class those affected are the first molars, incisors and canines, which present all the characteristics of a typical set of stomatitic teeth just described. The parts of teeth affected suggest that some cause has acted to impair their structure from shortly after birth to about two years of age. In the second class the teeth affected are the incisors and canines, and more rarely the second molars. This defect may in some cases take the form of a row of pits crossing the crown transversely, in others a depressed line of defective enamel, and sometimes a terraced condition is noticed, showing a repetition of the cause of imperfect formation. The incisive edge is always perfect in this class of teeth. The cause presumably acts for some short period during the first four years of life or in some cases later. Mr. Bennett found the majority of patients possessing teeth described in the first class suffered from an eye defect known as lamellar cataract. He also examined patients possessing teeth of the second class, and in no case did he find these to be associated with the defect eye, but he was generally able to obtain histories of distinct illnesses. Mr. Bennett believes errors in feeding and malnutrition to be the cause of lamellar cataract, and considers that this is also the cause of the defective teeth found in association with it. With regard to the second class, he believes that exanthematous fevers are without doubt the cause of defect, and it should be clearly distinguished from the first class. We know that in children exanthematous fevers sometimes give rise to necrosis of the jaws, therefore it seems possible that they could be capable of causing sufficient inflammation or stomatitis to affect the developing teeth in some cases. But probably Mr. Bennett considers them to cause general rather than local affections. Perhaps the following theory, suggested by Dr. Jacobi, would, if correct, explain how stomatitis or inflammation of the mouth could affect developing teeth. He thinks that the mucous membrane of an infant's mouth is very susceptible to irritation, being accustomed to a mild fœtal liquor during intra-uterine life and adapted for milk during extra-uterine life. Some children, especially in poorer districts, before they are many weeks old, are given candy to suck, crusts of bread, coffee, beer or rum, in fact, anything to ensure repose. Dr. Jacobi considers this to be quite sufficient to set up inflammation of the mouth, which would spread to the deeper tissues, thus affecting the developing teeth. As one of the results of inflammation stosis may occur in some of the blood vessels supplying the enamel organ, leading to a deficiency of blood and consequently of lime salts. Thus we get imperfect calcification. Again, effusion may take place from the blood vessels, and if that be so, Dr. Jacobi considers the cause of discolouration to become more intelligible.

Possibly this theory would hold good in some cases, but it would be difficult to believe that hypoplastic teeth seen in members of good families are brought about by such causes suggested by Dr. Jacobi, namely, too early administration of beer, rum, etc. Rickets has been supposed by Salter and other observers to occasion defective structure of the permanent teeth, but Mr. Norman Bennett has found no evidence that rickets by themselves can rank as cause, but thinks that rickets may be present among the general affections caused by errors of feeding and malnutrition.

There seems to be a consensus of opinion among some medical writers that rickets affects the structure of temporary teeth. Some say the teeth are rocky and pitted and quickly break away. Others that the teeth when erupted are deficient in enamel, and many more authors could be quoted. Denison Pedley opposes this view, saying that calcification appears in the temporary teeth about the eighteenth week of fœtal life. If fœtal rickets were a common complaint, we should expect to find some modification in that part of the crown first formed. But it is comparatively rare. Again, if rickets were common within the first three months of birth, we should expect to see some alteration in that portion of the temporary teeth which proceed in formation after birth. But most authors are agreed that rickets are developed after the first three months of life and are due to too much starchy food. Kassowitz, an Austrian observer, considers the earliest indication of rickets to be beading

of the ribs at the costo-chondral junction, and that at least 80 per cent. of the Vienna children are more or less rickety. Dennison-Pedley says that if beading of the ribs can be regarded as sufficient evidence of rickets, he can go even farther and say that almost all children of the London poor can be considered rickety. In conjunction with Dr. Carpenter he has examined five hundred cases of well marked rickets at Evelina Hospital, and in the vast majority of cases the teeth were perfect, but in many cases there was no doubt that dentition was considerably delayed.

To return again to the permanent dentition. Cases are occasionally seen of a single defective bicuspid among a set of teeth otherwise perfectly normal. Abscess of the preceding temporary tooth leading to alteration of the blood-supply and thus defective calcification of the developing permanent tooth, is thought by some to cause the defect. But remembering that the second temporary molar is erupted about twenty-six months after birth, and that calcification of the bicuspid is stated to occur about twenty-four months after birth, it would appear that abscess must occur in the temporary molar at about the age of two and a half years, or earlier, in order to affect the crown of developing bicuspid.

But is it a usual occurrence for children to have abscessed temporary molars so young? Should it occur about the fifth or sixth year, which is a more probable time, the crown of bicuspid is well on its way to completion and could hardly be affected by such a cause.

Again, Mr. Spokes has published some statistics of defective teeth in which thirty-seven cases of bicuspids were met with, and in no case did the records show abscess of the preceding temporary teeth. On the other hand, eight instances of abscessed temporary molars were recorded, which were followed by bicuspids of perfect structure. These facts do not seem to support the view of diseased temporary teeth as cause.

With regard to hypoplasia of temporary teeth, although somewhat rare, there is no doubt that it occasionally exists. Out of two hundred and fifty infants examined by Mr. Spokes, fifteen possessed hypoplastic teeth. He considers that the cause must arise during fœtal life, and that probably prolonged attacks of vomiting which sometimes occur during pregnancy would sufficiently interfere with the nutrition of the mother to affect the developing teeth of the fœtus. Dr. Grevers thought that he had sometimes seen cases of affected temporary teeth, but upon inquiry he found that when the children were about twelve or eighteen months of age they were given to suck a mixture of sugar and bread placed in linen bags. This, he considers, would set up erosions of the enamel which might easily be mistaken for hypoplasia.

Mr. Payne holds an opinion concerning hypoplasia which would certainly throw light on some rather inexplicable facts. He believes that various affections, such as exanthematous fevers, disturbances caused by errors in feeding, stomatitis, abscess or ulceration from whatever cause arising, do not affect developing teeth in the way generally supposed, viz., interference with the calcification of their enamel and dentine, but as result of these affections some change takes place in the deeper tissues, giving rise to a secretion which is capable of decalcifying those parts of the teeth already formed. Thus we may take it that Mr. Payne considers the cause of defect to act after, and not during calcification. In support of this opinion are the following suggestions:—

(1) The microscopical appearance of a hypoplastic tooth is similar to the appearance which would be produced by the action of external agencies on that portion of a tooth whose calcification is complete.

(2) If the effect is due to causes acting upon the tooth germ prior to or during calcification, why is the outer layer of dentine and the enamel affected only, while the cementum and greater portion of dentine is well formed?

(3) Hypoplastic temporary teeth could be better accounted for in the light of this opinion, for one can understand that the parts formed at birth, viz., half crown of central, less of lateral, etc., might be affected in the way suggested. Again, abscess of the temporary molar affecting the formed crown of bicuspid could be understood in the same way.

Hypoplastic teeth may well be contrasted with syphilitic teeth, where the whole tooth germ is undoubtedly affected.

Such are some of the views concerning dental hypoplasia. To summarize, we might say that syphilitic teeth are due to causes acting upon the whole tooth-germ whereby not only the structure but the whole form of tooth is impaired, and these teeth are generally accompanied by other evidence of that disease, viz., interstitial keratitis, skin affections, etc.

Hypoplastic teeth are occasionally accompanied by lamellar cataract and are due to causes acting upon enamel and dentine during or after calcification, and interfering with their structure only, and of these cause errors of feeding and exanthematous fevers are the most probable. In conclusion, gentlemen, I thank you for your kind attention to what I fear has proved none too interesting a paper.

Samples.

WE have received several samples of drugs and foods which are undergoing examination. With regard to this, we should like to point out that we notice favourably only those things that we have deliberately approved of from a strict professional standpoint and after a critical consideration. We cannot insert defamatory notices, and we are unwilling to insert anything laudatory that the article in question does not absolutely deserve on its merits, but if the proprietors are anxious for us to insert our deliberate opinion, even if unfavourable to their claims, we are always ready to do so at their request, subject to the usual limitations of space.

Things Reflected On.

I suppose that to most of us, the time spent in walking the hospital is, in itself, sufficient food for thought, and to others, a matter of regret. This, however, is not entirely in our own hands, and rests, more than we should desire, on the views of the small but well armed tribe of examiners. I must at once state that I do not agree with the band of unfortunates who hold all examiners in deepest contempt, and see in them the hereditary enemies of our calling, enemies crafty and malicious, who throw every obstacle in the path of the innocent candidate, and after subjecting him to the tortures of the inquisition thrust him in o an outer world with ill-concealed glee. This view always brings to my mind the iron entering into the soul.

But everyone will admit that the Goddess of Chance should be worshipped in lowly reverence by candidates, and I for one will bow down my head and burn sweet lobelia before her shrine for her greater glorification. One of my greatest regrets in these days is the time I spent at lectures, for I now see looking back from a perfectly unbiassed standpoint, that it was only from a gifted few that I learnt anything. Unfortunately I had to attend lectures by an ungifted majority, who, if they ever had a talent given them must have wrapped it in a napkin and buried it in the Park. This did not occur to me all at once, for when I was young and foolish I thought of lectures as the sole aim of man. I grew wiser and withdrew modestly to the "hills" where I steadily learnt how the world wagged for the modest sum of one half-penny. Later I stayed away altogether, and entrusted my frail craft to the mercies of an indulgent Dean to steer her through the intricacies of a signing up. She survived in face of overwhelming odds.

My modest library always conjures up many thoughts. It is not so large as it was, for I burned many bridges behind me. Many of those volumes that I had wrestled with had their pleasing use, for they "raised the wind" that bore me away on a holiday. I often wonder how much I have read and how much remains. Is this my fault or the books? I have given this question much thought, and have arrived at the brilliant result that it must lie with both. Now that medicine is becoming so exact, I fancy that books lose all their charm. Do we nowadays write such books on medicine with the charm that Fagge gave to his?

Looking at the books commonly read, I think, with a few exceptions, that we do not. The stock phrases of the medical wards are now so much used that the literary charm, which in no way detracts from the merit of a medical work, is banished for ever. Should we not hail with delight an up-to-date book that reads with the delightful freshness of "Common Neuroses." And after all it should not be a vain longing. If we progress in the direction in which we are now going, the rest will be a luxury in medicine, for all we shall need will be lists of symptoms and signs.

The question Why? is one always before the human mind. It may be only on the lowest intellectual level, such as "Why did the lobster blush?" or on one of the highest, such as the causation of disease. But it seems fair to demand an answer that should convey some meaning, or a frank confession of ignorance. It cannot be expected that we should always be able to attain to the former, and yet how seldom the latter appears in a medical work. If we look for knowledge in pathology, the author generally seeks the Refuge for the Indigent Blind, and tells us that the disease is probably due to the action of some undiscovered toxine. This is naturally very edifying, but its value is not of the best. In accounts of treatment I always encountered the familiar "Each case should be treated on its own merits" with the deepest loathing. It always forced me to think that the author was incapable of laying down any suggestion, much less law, on the subject.

Dogma, I know, is always inveighed against—needlessly, I think, as it is most useful when one has not the experience necessary for judgment, and we have all gone through that stage. Aphorisms might also occupy a more prominent position. Not books of aphorisms, which appeal to one about as much as a list of the Kings of England, but aphorisms interspersed in a good book, or in one of the gifted men's lectures, much as trite sayings occur in a good history.

A well-adjusted use of dramatic writing is often invaluable, and well I remember the case of young Alexis St. Martin, who had a wound in his stomach. The gifted author held me spellbound as he narrated how Dr. Beaumont pursued him even beyond Jordan, or to the banks of Hudson Bay. I forget which.

And lastly, the saving grace of humour. Some few teachers are blessed with it, yet how seldom it finds its way into the pages of a scientific work, and no one knows why. It cannot detract from its value. Of all the theories of malignant disease, the one that is most impressed on my mind is that so beautifully condensed by the humorist as being the result of a cross between a white corpuscle and a connective tissue cell. Humour, I know, is not altogether wanting in some of the works of our writers, but by all means let us have more if possible. Let us learn by the agreeable method of amusement combined with instruction.

A MEDICAL IDLER.

Papers by Guy's Men.

A Clinical Lecture on some Cases illustrating the Diagnosis of Typhoid Fever. By W. Hale White, M.D., F.R.C.P.—*Clinical Journal*, 17th December.

General Pathology of Infection. By E. W. Ainley Walker, M.A., M.D.—*Ibid.*

HOUSE APPOINTMENTS.—The following were appointed to Mr. Jacobson: F. C. Wetherell. Mr. Lucas: C. H. Robertson. The Front Surgery—O. W. Richards, A. R. Thompson. The Back Surgery—S. Hodgson, G. T. Wrench. Mr. Lane: D. H. Trail. Mr. Dunn: N. H. Houghton. Mr. Fripp: F. L. Thomas. Mr. Steward: M. J. Rees.

Sport.

Rugby Football.

GUY'S v. OLD MERCHANT TAYLORS.

An enthusiastic crowd of spectators witnessed this match which was played at Honor Oak Park on Saturday, November 22nd, and resulted in a fast and evenly contested game. A keen east wind was blowing throughout. The ground was in fair condition.

O'Brien, winning the toss, elected to defend the pavilion end, and Fletcher kicked off at 3.20. Play opened in mid-field. Guy's forwards, playing with great vigor, carried the first scrum, and smart footwork in the loose gained much ground. An excellent collar and dribble by O'Brien looked dangerous. Several tight scrums, in which the O.M.T.'s pack was seen to great advantage and frequently got the ball followed; but from a free kick for foot up O'Brien found touch. Fast and open play revealed excellent work by Guy's forwards who were well together, and, in the loose, brilliant. A free kick enabled Fletcher to make a fine effort to place a goal, the wind just turning the ball wide. An intercepted pass threatened danger, but O'Brien, who was playing one of his very best games, tackled well. Pressure was relieved by Anderson and Alcock, the latter finding touch at half-way with a good punt. Valuable efforts by Harrison, Louisson, and McEvedy enabled Guy's to attack hotly. Shortly afterwards McEvedy beautifully gathering a high punt by Louisson ran into the O.M.T.'s twenty-five, but their defence was very sound. Several bouts of passing by their three-quarters were rendered futile by the fine tackling of Louisson, O'Brien and McEvedy. A mark and excellent kick by Harrison relieved. Walker and Wall, playing with great dash, carried the ball to the O.M.T.'s goal line, but a kick for off-side robbed Guy's of the advantage thus gained. An excellent effort by O'Brien to drop a goal just failed. Good play by Walker and Alcock found Guy's still pressing at half-time:—

GUY'S	...	...	...	Nil.
O.M.T.'S		...	...	Nil.

In the second half the game was very fast. Tolhurst kicked off and Guy's were soon attacking, the forwards heeling smartly and thus giving the three-quarters frequent opportunities, which they were not long in turning to account, for, within five minutes of resuming, smart work by O'Brien and McEvedy enabled Alcock to make one of his characteristic runs and score; far out O'Brien made a good effort to convert. After the drop out play soon returned to the O.M.T.'s territory and some exciting scrums took place on their goal line. Louisson was conspicuous again and again for his fine tackling, and was playing a great game. In quick succession the ball travelled from one end of the field to the other, Harrison on several occasions saving well. A fine piece of play by the Guy's forwards carried the ball half the length of the field, and Brown and O'Brien made good runs. With long kicks—finding touch—Walker and Harrison gained much ground. Following several good bouts of passing by the behinds Louisson made a mark, and from his kick the O.M.T.'s touched down. Through Walker Guy's again pressed, a splendid run by Alcock almost let Anderson in. A forward rush relieved, and twice in quick succession Harrison was called upon to save. McEvedy and O'Brien were again conspicuous, the former making a strong run into the O.M.T.'s twenty-five, the latter showing good defence. Walker getting the ball smartly away from the scrum, passed to McEvedy who, making a good opening, transferred to Alcock, who again scored far out. A fine kick by O'Brien just failed to convert. On resuming the O.M.T.'s three-quarters broke right away and a try seemed inevitable, when Alcock, dashing across from his wing, saved brilliantly, well in Guy's twenty-five. No side followed. Result:—

GUY'S	...	...	2 tries (6 points).
O.M.T.'s	...	...	Nil.

Team:—

GUY'S.—E. M. Harrison (back); F. Alcock, A. O'Brien, P. F. McEvedy, H. S. Brown (three-quarters); W. G. Louisson, F. E. Walker (half-backs); A. H. E. Wall, R. G. Anderson, B. Glendinning, E. L. Ward, E. H. Milsom, S. M. Saunders, A. M. Tolhurst, W. G. Pinching (forwards).

Referee: Mr. Geo. Harnett. Linesman: Mr. E. Morgan.

REMARKS.—All the forwards, without exception, played well throughout. Marked improvement was noticed in the heeling, and in the loose they were brilliant, quite out-playing the sound pack of forwards opposed to them. The most satisfactory improvement was the increased energy displayed in scrummaging, careful attention failing to reveal any non-workers. At half, Louisson played a great game, undoubtedly the best he has yet played for Guy's. Walker, who took O. V. Payne's place, who is still on the injured list, played his usual sound game, and was of great value to the Hospital. The feature of the good form shown by the other behinds, was O'Brien's display at centre; his tackling, kicking and skill in making openings was perfect and delightful to watch. Brown, who took Morgan's place—absent through injury—on the wing did well. Harrison was very safe at back.

GUY'S v. LONDON SCOTTISH.

This match, which was played on December 12th at Richmond in dull, moist weather, was most interesting to watch, and resulted in a creditable win for Guy's. After several determined rushes by the Scottish forwards, play settled in the Scottish territory. Our forwards carried the scrums and heeled out well, and the Guy's three-quarters came very near scoring again and again, but their passing was rather erratic at first. Alcock made several strong and characteristic attempts to get in, running, dodging and handing-off in grand style. After some

pretty passing by Louisson, Harrison, McEvedy and Brown, the latter was collared after a good run. McEvedy soon afterwards nearly dropped a goal. Later, the Scotsmen played up vigorously, their forwards showing to great advantage in the loose. At half-time neither side had scored, although Guy's had been doing nearly all the attacking.

On resuming, the Guy's men showed better combination, and after some splendid passing by Louisson and O'Brien, McEvedy made a good opening for Alcock, who scored in a good position; Harrison converted. Soon afterwards the Scotsmen were unlucky in failing to score after one of their impetuous rushes from end to end of the field. Brown, after a good sprint, was well collared by Gibson when nearly over. Towards the end a remarkable change came over the game, and the Guy's men, working well together, outmanœuvred the Scotsmen. Alcock, after many efforts, secured another try far out. A few minutes later O'Brien got the ball well away to McEvedy in mid-field, and the latter, after racing along at a great pace, transferred to Harrison, who secured a well-earned try. Just before time, Louisson gave Brown a good opportunity, Brown dashed along the touch-line and secured the fourth and last try. Final score:—

GUY'S ... ... 1 goal 3 tries.
LONDON SCOTTISH ... Nil.

REMARKS.—Louisson never played a better game. Harrison was a great success as a three-quarter, and Wall, Anderson and Glendinning were the pick of a decidedly good pack of forwards.

Association Football.

GUY'S 3RD TEAM.

This team has played 10 matches this half-session—winning 3, losing 6, and drawing 1. As will be seen from the following list, several of the matches have been close.

	Club.	Result.	Goals For.	Goals Against.
1.	Old Colfeians ...	Lost ...	0 ...	2
2.	Ealing B	Lost ...	0 ...	5
3.	Mortlake Institute ...	Won ...	2 ...	0
4.	Old Colfeians ...	Lost ...	1 ...	2
5.	Neasden	Won ...	3 ...	0
6.	Brentwood Rovers ...	Won ...	9 ...	0
7.	Mortlake Institute ...	Lost ...	0 ..	1
8.	Camberwell House ...	Lost ...	1 ...	2
9.	Kestral 1st	Draw ...	0 ...	0
10.	Cheshunt 2nd ...	Lost ...	0 ..	2

Guy's Hospital Chess Club.

A match was played on Wednesday evening, 3rd inst., in the Reading Room, v. Selby House Chess Club, and resulted in a win for Guy's by 5 boards to 4, which was in a great measure due to Mr. E. W. Routley's splendid game at 5th board.

	Guy's C. C.		S. H. C. C.	
1.	B. H. Stewart ...	0	C. R. Hoon	1
2.	F. Chilton	0	J. Whicker	1
3.	T. C. Pocock	1	H. Völkl...	0
4.	P. R. Bolus	1	G. Völkl	0
5.	E. W. Routley ...	1	P. Phipps	0
6.	C. J. Dissmorr ...	1	P. A. Tomaszewski ...	0
7.	C. L. Leipoldt ..	1	E. O. J. Schultz ...	0
8.	O. S. Norton	0	H. H. Le May	1
9.	H. N. Eccles	0	H. Jackson	1

United Hospitals Hare and Hounds.

The race v. Wellington College Hare and Hounds on Saturday, November 22nd, resulted in a win for our opponents by 17 points to 19. The course was sandy at the finish, and about seven miles long. The two first places were obtained by Wellington men, while our team was weakened by the absence of J. S. Gibb and F. S. Lister, of Bart.'s, and O. S. Norton, of Guy's.

On Saturday, December 6th, the Blackheath Harriers also defeated the Hospital team, and it was interesting to note that three Guy's men counted the first three of the Hospital team, namely, O. S. Norton 1st, E. L. Pilbeam 4th, and T. E. A. Carr 8th. We were unfortunate in the fact that J. S. Gibb and P. Gosse both suffered from sprains during the race, and G. A. Simmons of St. Thomas's was away.

The Blackheath Harriers gave a splendid smoker to the team, Mr. J. H. A. Reay, the veteran hurdles champion, took the chair and toasted the medicos, Dr. H. A. Munro also spoke, and regretted that other hospitals did not back the club up. Mr. E. W. Griffin, of Guy's, replied. Scores as follows:—

		M.	S.
1.	O. S. Norton, Guy's	42	5
2.	T. C. Davis, B. H.	42	25
3.	E. F. Judson, B. H....	42	36
4.	E. L. Pilbeam, Guy's	42	50
5.	E. R. Small, B. H.	43	50
6.	W. H. Manning, B. H.	44	5
7.	P. Plumstead, B. H.	44	11
8.	T. E. A. Carr, Guy's...	45	5
9.	W. G. Suffield, B. H.	45	43
10.	W. H. Orton, Bart.'s	45	55
11.	P. Gosse, Bart.'s	46	30

Hockey Club.

A general meeting of the Club was held on Tuesday, December 16th, Mr. Steward in the chair. The following officers were elected:—President: Mr. Steward. Vice-President: Dr. Fawcett. Captain: M. Leckie. Vice-Captain: H. H. Moyle. Treasurer and Secretary: W. M. Mollison. The following were also elected to the Committee:—Messrs. Morres, Strange, Donnell, Brook-

house and Langdale; and to the ground committee Messrs. J. N. Smith, A. W. Ormond, L. Davies and Mollison (ex-officio).

It is proposed that the Hockey Club shall acquire a ground. In order that the ground committee may form some estimate of the sum available for the project, would intending subscribers kindly sign their names on the list posted in the smoking room. It is earnestly hoped that junior men will avail themselves of this opportunity to join the club.

There will be trial games after Christmas, which the committee trust will be well attended, as a team is to be chosen to represent the Hospital in the Inter-Hospital Competition.

Reviews.

The price of books submitted for review should in every case be stated.

Medical, Surgical and Pathological Reports of the Royal Southern Hospital, Liverpool. Vol. I., 1902. Price 2s. 6d.

The most interesting features of this excellent work to outsiders are the author's account of the well-known Alexander Adams' operation and the printed post-mortem records at the end. Would that our own records were as easily accessible to the general reader, and not so buried. Other interesting points are the cases of duodenal ulcer, which, with its cousin gastric ulcer, is quite the burning question of the day.

Appointments.

CIVIL.

BRODRICK, CHARLES C., L.R.C.P., L.R.C.S., L.M. Edin., has been re-appointed Medical Officer of Health for the Tavistock (Devon) Urban District for three years.

BURGHARD, F. F., M.S., F.R.C.S., has been appointed teacher of Operative Surgery at King's College, London.

HARSANT, WILLIAM HENRY, F.R.C.S. Eng., has been appointed Honorary Consulting Surgeon to the Bristol Royal Infirmary.

LAVERS, NORMAN, M.D. (Brux.), M.R.C.S., L.R.C.P., has been appointed Medical Superintendent of the new Asylum for the County Borough of Canterbury.

MORGAN, THOMAS, L.R.C.P. Lond., M.R.C.S., has been appointed House Surgeon to the Brecon and County Infirmary.

ROBINSON, J. F., F.R.C.S. Eng., has been appointed Senior House-Surgeon to the Croydon General Hospital.

TASKER, B. G., L.D.S., F.R.C.S. Eng., has been appointed Honorary Dental Surgeon to the Brighton, Hove, and Preston Provident Dispensary.

WILLAN, G. T., JUN., B.A. Camb., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer of Health to the Milton-next-Sittingbourne Urban District Council, and District Medical Officer to the Milton Union.

NAVAL AND MILITARY.

Surgeon SIDNEY CRONEEN, R.N., has been appointed to the *Odin*.

Captain F. S. BRERETON, R.A.M.C., resigns his commission.

Surgeon-Captain R. J. BRYDEN, Army Medical Reserve of Officers, is promoted to be Surgeon-Major.

Surgeon-Captain R. G. P. LANSDOWN, 1st Gloucestershire Royal Garrison Artillery (Volunteers) resigns his commission.

Lieutenant JOHN MATTHEWS, R.A.M.C., is promoted to be Captain.

Surgeon-Lieutenant A. W. SHEEN from the 3rd Volunteer Battalion the Welsh Regiment, to be Lieutenant in the Welsh Volunteer Infantry Brigade Bearer Company.

Surgeon-Lieutenant ERNEST H. TIPPER, 1st City of London Royal Garrison Artillery (Volunteers) is promoted to be Surgeon-Captain.

On account of the large number of candidates presenting themselves at the Cambridge University, Dr. E. Cooper Perry has been appointed an additional examiner for the M.B. degree (Third Examination, Part 2).

From the Gazette's Special Pathologist.

Directions to be followed in sending *Diphtheritic Membrane*:—Remove as much of the membranous exudation as possible with a pair of forceps, which have been sterilized by boiling water. Place the exudation in a small, perfectly clean empty bottle, with a well-fitting glass stopper, and forward without delay. No preservative fluid should be used. The specimen must be accompanied by a Postal Order for 5s. A telegram will be despatched immediately the examination of the specimen is completed.

X. Y. Z., HASTINGS.—This specimen contained but little pus, and no tubercle bacilli were detected in it.

PATHOLOGIST.

Marriages.

EYRE—PARNELL.—On Thursday, December 11th, in London, John William Henry Eyre, F.R.S. Edin., M.D., to Ethel Grigg Parnell. No cards.

RICHARDS—KNOWLES.—On November 29th, at St. Saviour's, Westgate-on-Sea, Joseph Stewart Richards, M.D., B.S., D.P.H., St. Saviour's Infirmary, East Dulwich, to Hilda, third daughter of Walter Thomas Knowles, of Comberton, Westgate-on-Sea, and Homleigh, South Croydon.

ED.—J. M. B.

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